Public Health Scotland

Evaluation of the National Mission on Drug Deaths
Lived experience survey

15 July 2025

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At a glance

In 2024, we ran a survey of individuals with experience of using drugs, as part of the PHS evaluation of the National Drug Deaths Mission. We wanted to explore their views on the support currently available to them, including from Alcohol and Drug Recovery Services (ADRS). We also wanted to explore their views as to whether they felt the support experience has improved. We received 494 responses.

What is the support experience currently like?

- Just over half of respondents reported that, overall, they were receiving all or most of the support they needed. 14% reported that they were getting none of the support they needed.

- Counselling and mental health support, one-on-one, had the highest levels of unmet need (47%) and total demand (i.e. met and unmet need combined, 81%). Peer support (for example, recovery cafés or networks of people who use drugs) had the second highest level of total demand (67%). Residential rehab had the second highest level of unmet need (29%).

- Six in ten respondents rated the overall care from their local ADRS in the last 12 months as excellent or good. Two in ten rated this care as poor or very poor.

- Half of respondents had experienced stigma or discrimination from their local ADRS at some point in the last 12 months. Half had not.

- Four in ten respondents had received their first dose of opioid-substitution therapy (OST) on the same day or the day after they asked for a prescription. Just over six in ten had received their choice of OST medication.

- Some groups were less positive about the ADRS support offer or were more likely to report unmet needs, including for example female respondents, those who were homeless, those living in rural areas and those reporting stimulants as their main problem drug.

- More than eight in ten respondents felt that recovery groups, such as recovery cafés, had been supportive. Almost seven in ten felt that family and friends had been supportive.

Has the support experience improved?

- Seven in ten respondents felt the support they were receiving from services now was better than two years ago. Two in ten felt the support was now worse.
- Respondents reporting a problem with opioids were more likely to say that the support was better now than two years ago.

Conclusions

The survey provides some evidence which suggests that the support experience may have improved. However, the survey findings also suggest that there are substantial ongoing challenges and scope to improve the support offer.

The survey findings are not based on a representative sample: they need to be interpreted alongside the detailed information on who responded to the survey.

Executive summary

What we did

We undertook a survey of individuals with current or past experience of using drugs, as part of the PHS evaluation of the Scottish Government's National Drug Deaths Mission.

The survey aimed to explore:

- their views on the support currently available to them, including from ADRS
- their views as to whether the support offer from services has got better or worse over the last two years
- the feasibility of establishing an ongoing national mechanism to collect, in a robust and coordinated manner, feedback from individuals with experience of using drugs, on the support available to them.

The survey took place in the second half of 2024. Individuals could complete the survey online or use a paper copy. Individuals could complete the survey on their own or with the support of a peer researcher from the Scottish Drugs Forum (SDF).

This study has a number of limitations. These limitations are linked, in part, to the challenges involved in capturing feedback from individuals with experience of using drugs, at scale. The main limitation is that the survey findings are not based on a representative sample. They need to be interpreted alongside the detailed information on the characteristics of those who responded to the survey.

What we found

The response to the survey

In total, 494 responses were received. The bulk of responses (419 or 85%) were entered on the online platform with the help of an SDF peer research interviewer.

Responses were received from across 27 different Alcohol and Drug Partnership (ADP) areas. Two thirds of respondents were male and one third were female. Just fewer than one in five (18%) came from rural areas. Just over one in five (22%) respondents were homeless. Finally, 15% had not used drugs in the last six months – this last group was interpreted as being in recovery for the purpose of subgroup analysis.

Some groups are likely underrepresented in the survey. For example, just fewer than 5% of respondents were younger than 25. Only 1% were in prison or a youth offenders' institute. Almost all reported their ethnicity as white. Those in contact with peer support groups or with their local ADRS are likely overrepresented.

Treatment and care received

Respondents were presented with a list of treatment and care options. They were asked which treatment and care options they had received in the last 12 months, and what options they would have liked to receive but were unable to access. The responses to this second question were interpreted as unmet need. The responses to both questions were combined to give a proxy indicator of total demand.

Table 1 provides a summary of the responses. A more detailed description of the treatment and care options included in the survey questionnaire can be found in **Appendix 3**. For example, the questionnaire described peer support as recovery communities, recovery groups or cafés and networks for people who use drugs.

Table 1. Summary – support received, unmet need, total demand

Treatment and care options	Support received (n = 473)	Unmet need (n = 414)	Total demand (n = 411)
Mental health support one-on-one	47%	47%	81%
Peer support	61%	13%	67%
A naloxone kit	56%	3%	58%
Housing support	33%	25%	51%
Other harm reduction	35%	9%	42%
Mental health support in group	20%	21%	40%
Residential rehab	12%	29%	38%
MAT / OST	35%	6%	36%
Detoxification	15%	15%	31%
Employment support	12%	13%	23%

Note: The 'total demand' column tends to be lower than the sum of the 'support received' and 'unmet need' columns. This is because respondents could report that they had accessed a certain treatment option and still report it as an unmet need. Access to residential rehab (12%) is likely inflated because of selection bias: we know from **other data sources** that only 989 individuals accessed a placement for drugs or co-dependency in 2022/23, the last year for which those data are available.

One-on-one mental health support had the highest levels of total demand (81%) and unmet need (47%). Peer support was the option with the second highest level of total demand (67%). Residential rehab was the option with the second highest level of unmet need (29%).

Female respondents, homeless respondents, those living in rural areas and respondents in recovery were more likely to report some of these unmet needs.

Spotlight on access to naloxone

Among those who had received naloxone in the last 12 months, 38% reported that they had already used their naloxone kit. Female respondents were as likely as male respondents to have already used their naloxone kit. They were, however, less likely to have received a kit, possibly suggesting an opportunity for service improvement.

Spotlight on access to OST

Among those reporting a problem with opioids, 57% had accessed OST and 13% reported an unmet need for OST. Total demand in this group stood at 62%.

Among respondents who had received OST in the last 12 months, four in ten (41%) had received their first dose on the same day or the day after they asked for their OST prescription. The **same-day prescribing MAT standard** states that all individuals accessing services have the option to begin medication on the day they ask for help. The 41% percentage is lower than may have been expected based on the assessment of compliance with the same-day prescribing MAT standard in the **2025 PHS MIST benchmarking report**.

Just over six in ten (63%) respondents reported that they had received their choice of OST medication.

Perhaps counterintuitively, unmet need for OST was concentrated among respondents who had received OST in the last 12 months. This finding possibly provides an additional argument for ongoing efforts to improve the OST offer for those already in receipt of OST.

Spotlight on mental health support

Mental health support emerged as the most prominent unmet need in the free text responses. Many of those free text comments related to support from specialist mental health services. Free text comments also reflected a need for human connection and for more trauma-informed ways of working.

Experience of trying to access support

Overall, just over half (52%) of respondents reported that they were getting all or most of the support they needed. 14% reported that they were getting none of the support they needed.

Accessing support from statutory services

Pharmacists emerged as the statutory service which was most likely to have been experienced as supportive rather than unsupportive, followed by local ADRS and mental health workers. Respondents were four times more likely to describe their pharmacist as supportive than as not supportive. GP practices were less likely to be experienced as supportive, but more respondents still described their GP practice as supportive than as not supportive.

Spotlight on support from local ADRS

Three in four (74%) respondents had received support from their local ADRS in the last 12 months. Respondents in recovery were less likely to have received ADRS support. Those reporting a problem with opioids were more likely to have received this support.

Six in ten respondents rated the overall care from their local ADRS in the last 12 months, and the quality of their relationship with their ADRS key worker, as excellent or good. Half (49%) of respondents reported that they had experienced stigma or discrimination from their ADRS at some point in the last 12 months. Half had not.

Female respondents and homeless respondents were less likely to report a positive ADRS support experience. Respondents reporting stimulants as their main problem and those reporting a problem with benzodiazepines were also less likely to provide a positive rating. The frequency of ADRS appointments was also linked to respondents' rating of ADRS support: those seen less frequently by their local ADRS were less likely to provide a positive rating.

Spotlight on support from family, friends and recovery groups

Family and friends and recovery groups tended to be perceived as supportive. For example, more than eight in ten (85%) felt that 'other recovery groups', such as for example recovery cafés, had been supportive and only 1% felt these groups had not been supportive.

The support from recovery and other third sector and community groups was experienced as positive by all respondents who commented on this in a free text comment. This stood in contrast to the free text comments in relation to the statutory support experience, which were a mix of positive and negative comments.

Changes to the support offer over time

Seven in ten (69%) respondents felt that the support they were receiving from services now was better than two years ago. Two in ten (21%) felt the support was now worse. Those reporting a problem with opioids were more likely to feel that the support was better.

Those who felt that the support offer had improved were asked why they thought things were improving. They were most likely to tick the response options that they were now getting support more quickly or were now treated with more respect.

Those who felt that the support offer was now worse were asked why they thought things were getting worse. They were most likely to tick the response options that they now had to wait longer for support or were seen less often.

Conclusions and considerations for policy

The survey findings are not based on a representative sample: they have to be interpreted alongside the detailed information on who responded to the survey.

The survey provides some evidence which suggests that the support experience may have improved. However, the survey findings also suggest that there are substantial ongoing challenges and scope to improve the support offer.

The evidence suggesting progress possibly argues in favour of a degree of continuity, giving time to local and national organisations to continue existing quality improvement efforts. However, the evidence of substantial ongoing challenges indicates that additional and more targeted focus is needed in some areas, including for example:

- Mental health support, including improving access to specialist mental health services and embedding trauma-informed working across services
- Investment in peer support and third sector, community and recovery groups
- The support offer in relation to non-opioid drug use, including stimulants
- The needs of groups facing additional disadvantage, including for example individuals who are homeless.

The Scottish Government may also wish to consider establishing a longer-term research project to allow aspects of this survey to be repeated.

Abbreviations used in this report

ADP Alcohol and Drug Partnership

ADRS Alcohol and Drug Recovery Service

DAISy Drug and Alcohol Information System

HACE Health and Care Experience Survey

MAT Medication-assisted treatment

MIST MAT Standards Implementation Support Team

NESI Needle Exchange Surveillance Initiative

OST Opioid-substitution therapy

PHS Public Health Scotland

SDF Scottish Drugs Forum

SHeS Scottish Health Survey

Selected key terms used in this report

Unmet need and total demand

Survey respondents were presented with a list of treatment and care options. They were asked which of those they had received in the last 12 months. They were asked separately which options they would have liked to receive but were unable to access in the last 12 months. The responses to the second question were interpreted as unmet need. The responses to both questions were combined to give an indication of total demand.

Mental health support

Mental health support was not defined in the survey questionnaire as such. The wording used ('counselling or mental health support, one-on-one or in group') nudged respondents to interpret the question as referring to talking therapies.

Peer support

'Peer support' was defined in the survey questionnaire as, for example, recovery communities, recovery groups or cafés and networks for people who use drugs.

Recovery

Recovery was not defined in the survey questionnaire as such. Mutual aid groups were defined as, for example, 12 Step Fellowships or SMART Recovery. 'Other recovery' was defined as, for example, recovery groups or cafés. It referred to groups other than mutual aid groups.

For the purpose of subgroup analysis, respondents were considered as being in recovery if they had not used illicit drugs within the last 6 months. They were considered as not in recovery if they had used illicit drugs within the last month.

Other harm reduction support

'Other harm reduction support' was defined in the survey questionnaire as, for example, needle exchange or wound care. It referred to harm reduction support other than naloxone, which was included separately as a response option.

Acknowledgement

PHS wishes to thank all individuals with experience of using drugs who participated in the survey.

PHS also wishes to thank all those who shared their time and expertise to support the development, piloting and dissemination of the survey questionnaire, and the interpretation of the survey findings. A special word of thanks goes to the SDF team of peer researchers, who helped individuals complete the survey.

Introduction

About the National Drug Deaths Mission

Background

In January 2021, the First Minister at the time announced a new National Mission to reduce drug deaths and improve the lives of those impacted by drugs. The **National Mission on Drugs Deaths: Plan 2022** – **2026** sets out the key outcomes and cross-cutting priorities that underpin the work. The National Mission runs until the end of March 2026.

PHS evaluation of the National Drug Deaths Mission

PHS was asked by the Scottish Government to evaluate the National Mission.

The evaluation covers the period between January 2021 and March 2026. The primary purpose of the evaluation is to help learn lessons around what is (and is not) working well in the National Mission – in order to ultimately improve the support offer and outcomes for individuals with experience of using drugs.

PHS published the **National Mission evaluation framework** in May 2024.

How this report fits within the wider evaluation framework

This report relates to one of the overarching evaluation questions of the PHS evaluation: are better outcomes being achieved? More specifically, this report asks whether there is evidence which suggests that the support offer from services may have improved. This links back to the fourth outcome in the Scottish Government's National Drugs Mission Plan 2022-2026: people receive high quality treatment and recovery services.

This report relates to the third work package of the PHS evaluation: collecting feedback from individuals with experience of using drugs.

This work package sits at the heart of the PHS evaluation. Other work packages in the evaluation have already explored whether, for example, **staff in frontline alcohol and drug services** or **senior drugs stakeholders** in Scotland think that the support offer has improved. It is important to also ask individuals with experience of using drugs themselves whether they have noticed any change.

About the PHS lived and living experience survey

Aims of the survey

The aims of the survey were to explore:

1. The views of individuals with experience of using drugs on the support currently available to them, including from ADRS
2. Their views as to whether the support offer from services has got better or worse over the last two years
3. The feasibility of establishing an ongoing national mechanism to collect, in a robust and coordinated manner, feedback from individuals with experience of using drugs, on the support available to them.

This report relates to the first two aims. A short paper presenting the methodology and findings of the feasibility component of the study will be published separately. This is because some of the feasibility questions cannot be answered before stakeholders have had an opportunity to fully engage with the published findings.

Methodology

Initial stakeholder engagement

This study was designed in close collaboration with stakeholders, including the Scottish Government, ADP coordinators, third sector partners and individuals with experience of using drugs. This was done through one-to-one consultations in late 2022 and early 2023 and a short-life working group in the spring of 2023.

Two key points were raised by stakeholders. First, stakeholders pointed to a proliferation of feedback exercises targeting individuals with experience of using drugs. They referenced, for example, the experiential feedback collected in the context of the Medication-Assisted Treatment (MAT) standards programme. Stakeholders raised concerns about the participation burden on local services being asked to facilitate these feedback exercises, and the risk of consultation fatigue.

Second, several stakeholders, including individuals with experience of using drugs, argued it would not be sufficient to only offer individuals the option to self-complete a questionnaire. Support had to be available.

Option analysis

Because of the concerns raised about the proliferation of feedback exercises, an option analysis was developed. This included a mapping of relevant existing data collection exercises (see **Appendix 1**).

The 'do nothing' option (i.e. work with existing feedback exercises instead) was rejected in consultation with stakeholders. The mapping confirmed that existing data collection exercises could not be used to robustly track whether quality of care, as experienced by individuals who use drugs, was improving over time.

To address concerns about the proliferation of feedback exercises, it was decided that the study would be set up as a feasibility study. One of the study's aims would be to contribute towards developing a better coordinated approach to collecting lived experience feedback going forward (see **Aims of the survey**). In addition, recognising the burden on local services, it was decided that the research would only work with those services and organisations that opted in to engaging with the research. Finally, it was decided that PHS would commission the SDF team of peer researchers to support completion of the questionnaire by individuals, and to further reduce the participation burden on local services and organisations.

Questionnaire development

A draft questionnaire was developed and shared with relevant teams in the Scottish Government, ADP coordinators and third sector partners. The SDF peer researcher group commented on the draft, as did staff and individuals with lived experience from the Scottish Recovery Consortium. The questionnaire was revised based on stakeholder input.

A question was included to check whether individuals had self-completed the questionnaire or had received support from someone else to do so. This question was added to help explore the feasibility component of the study. The question was also included to help assess risk of bias.

Target population

The survey targeted individuals who:

- Lived in Scotland
- Had experience of using drugs – this could be current or past experience of using drugs
- Felt that they had had support needs in the last 12 months, relating to their current or past experience of using drugs.

The survey did not only target those who had been able to access support – it was sufficient that individuals felt they had needed support. This could be any support need relating to their use of drugs – it did not only apply to treatment (such as OST or residential rehab) or only to support from statutory services.

Sampling

We were unable to use representative sampling: there are no detailed data on the exact composition of the target population (i.e. all individuals in Scotland who have experience of using drugs and who, in the last 12 months, have needed support). There were also resource constraints.

We might have been able to use representative sampling if we had limited the target population to those who had accessed support from ADRS in the last 12 months. There are data on the composition of that group through the **PHS Drug and Alcohol Information System (DAISy)**. However, it was considered important, following consultation with stakeholders, to also try capturing the views of those not in contact with services. There were ethical and human-rights-based considerations against excluding those not in contact with services. We were also concerned that only including those supported by services would increase the risk of systematic bias towards more positive views.

Instead, we used an element of quota-based sampling. Participation was monitored to track whether the following target quotas were being met:

- At least 20% female participants
- At least 20% participants in insecure housing
- At least 20% of participants from rural or remote areas.

These three dimensions were selected to help ensure that the views of those facing more complex needs or additional barriers (such as childcare or transport barriers) would be included. The quotas were set at 20% based on the characteristics of those accessing ADRS support, as recorded on **DAISy**, and the characteristics of those participating in the **Needle Exchange Surveillance Initiative (NESI) survey**. The proportion of female respondents sits at about 30% (as opposed to 20%) in those two datasets, but we wanted to allow a degree of flexibility given the possibility of recruitment challenges. **Table 5** in this report shows how the reach of our survey compares to the **DAISy** and **NESI** datasets.

Participants in insecure housing were defined as respondents who ticked the response option 'homeless – in temporary accommodation' or 'homeless – roofless'. Participants in secure housing were defined as those living in a property they rented or owned.

To define rural or remote areas, we used the two-fold Scottish Government urban/rural classification. We classified as rural areas those areas where 40% or more of the population reside in rural areas. Ten ADP areas were classified as rural: Aberdeenshire, Argyll and Bute, Dumfries and Galloway, Highland, Moray, Na h-Eileanan Siar, Orkney, Perth and Kinross, Scottish Borders and Shetland.

SDF was also asked to aim for at least 10 interviews per ADP area, with the exception of the islands, where SDF was asked to aim for at least 10 interviews across the three island ADPs combined. SDF was asked to aim for a higher number of interviews in areas with a higher number of drug-related deaths in 2023. The number of drug-related deaths per ADP area was taken as a proxy for the level of support need.

Data collection

The survey took about 20-30 minutes to complete.

The survey ran on the LimeSurvey online survey platform between July and December 2024. Individuals and organisations could request paper copies of the questionnaire, and pre-stamped envelopes to return the paper copies to PHS. The survey was advertised through social media by PHS and other national and local organisations. Posters to help advertise the survey (**Figure 1**) were made available to national or local organisations. SDF and the SDF team of peer researchers undertook proactive outreach to individuals with experience of using drugs to help increase participation. More detail about the methods used by SDF can be found in **Appendix 2**. Individuals who completed the survey via an interview with an SDF peer researcher were offered a £10 voucher.

Detailed participant information was made available. All prospective participants were asked whether they understood the information and agreed to take part in the survey.

Figure 1. PHS and SDF posters to help advertise the survey

Public Health Scotland

Do you have experience of using drugs?

Have you needed support in the last 12 months?

Are you interested in taking part in an online survey?

The survey will help to improve our understanding of what it's like for people with experience of using drugs to try getting the support they need in Scotland.

The survey is part of the Public Health Scotland (PHS) evaluation of the Scottish Government's National Mission on Drug Deaths.

If you have any questions about the survey, please contact the PHS Evaluation Team at phs.evaluationteam@phs.scot

Please scan to access the survey.

Would you rather take part in an interview?
Scottish Drugs Forum (SDF) peer researchers are organising short interviews, over the phone or in person, to go over the questions in the PHS survey. You can get a £10 voucher if you take part in an SDF interview. To take part, email SDF at **louiseh@sdf.org.uk** or call **07776 686407**

SCOTTISH DRUGS FORUM

Do you have experience of using drugs? Have you needed support in the last 12 months? Are you interested in taking part in a survey?

- The survey will help improve understanding of what it is like to get support in Scotland
- This is part of the Public Health Scotland evaluation of the Scottish Government's National Mission on Drug Deaths
- **£10 voucher** provided for taking part in short interview

TO TAKE PART CONTACT

✉ louiseh@sdf.org.uk

☎ 07776686407

You can also access the survey on your own by scanning the QR code below

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Data analysis

Quantitative analysis of responses to closed questions was done in Excel.

The analysis included subgroup analysis by demographic and socio-economic characteristics (gender, housing situation and rural vs. urban areas). We also undertook subgroup analysis based on patterns of substance use, including the types of drugs causing problems, whether respondents also reported a problem with alcohol and whether respondents were in recovery. Not having used illicit drugs in the last six months was used as a proxy indicator for being in recovery. For the purpose of the subgroup analysis, having used illicit drugs within the last month was used as a proxy indicator for not being in recovery.

We combined the data on the treatment and care options respondents had received in the last 12 months with the data on the treatment and care options they would have liked to access but were unable to in that same period. We used this as a proxy indicator for total levels of demand for different treatment and care options. Those who had accessed a certain treatment option and also reported it as an unmet need were only counted once.

No formal statistical testing was undertaken; data and percentages in this report present the result of descriptive analysis only. This is because:

- The study's data collection methods were not based on a representative sample. Undertaking statistical significance testing and presenting relevant findings in this report as statistically significant would have attached more weight to those findings than is appropriate.

- There are limitations to statistical significance testing of subgroup analyses. The large number of analyses undertaken risked identifying statistical significance by chance. Conversely, there was a risk that a difference was not recognised because there weren't enough responses from specific subgroups: a result that is not statistically significant may still reflect a difference.

The survey questionnaire consisted mainly of closed questions. Ten closed questions included an 'other' response option, which respondents could tick to then enter a free text comment. This included, for example, 'other' unmet needs. The questionnaire also included one stand-alone open question. This question invited respondents to share any other thoughts about their support needs or support experience.

The free text responses were analysed using thematic analysis. The analysis started with data familiarisation and initial coding. It then followed an iterative process of developing and reviewing themes. All free text responses were read by two researchers. One researcher did the initial coding and identification of themes. Codes and themes were then reviewed by a second researcher. Emerging themes were also sense-checked with the SDF peer researchers involved in the data collection.

Reporting

Several questions used rating scales. This report combines rating scale options to help improve readability (for example, combining 'strongly agree' and 'rather agree' into 'agree').

Respondents were asked which treatment and care options they would have liked to receive in the last 12 months but were not able to access. Throughout the report, we use 'unmet need' as a shorter, more user-friendly phrase to refer to this question. We used 'total demand' to refer to the combination of treatment received and unmet need (see **Data analysis**).

A number of free text responses are cited in this report. Long responses were edited. These edits are indicated by three full stops. Spelling mistakes were corrected, and punctuation was added to help improve readability. Potential identifiers, including names of staff, organisations or places, were removed. Generic wording in square brackets indicates where identifiers have been removed.

Information governance and ethics review

The project was reviewed and approved by the PHS Data Protection team and the PHS Internal Ethics Review Panel.

Limitations

It is important to acknowledge that this study has important limitations.

The findings are not based on a representative sample

First, the findings are not based on a representative sample. They cannot be generalised to the target population (i.e. all individuals in Scotland who have experience of using drugs and who, in the last 12 months, have had support needs). For example, this study cannot answer the question whether the target population, as a whole, thinks that the support experience from services has got better or worse over the last two years.

We have provided detailed information on the characteristics of those who responded to the survey (see **Part 1.** Respondent characteristics of this report). We have also included subgroup analyses to indicate whether survey findings apply to a lesser or greater extent to certain subgroups. We have also benchmarked the characteristics of survey respondents to the characteristics of those in the **DAISy** and **NESI** datasets (see **How representative or unrepresentative are the survey responses?**).

The survey findings need to be interpreted alongside this detailed information on the characteristics of respondents. For example, the target population also included those who had not received support from their local ADRS. We need to be mindful, when interpreting the survey findings, that only one in four respondents had not accessed ADRS support.

Limitations to the subgroup analysis

We did not include statistical significance testing of the subgroup analysis (see **Data analysis**). We also did not undertake subgroup analysis which combined different client characteristics, such as for example analysis by gender and drug use. An apparent difference between male and female respondents may instead be the result of differences in the drug use profile of survey respondents.

Risk of systematic bias towards more positive or more negative views

As with any survey, when it comes to questions which ask respondents to provide a rating, there is a risk of systematic response bias towards more positive or more negative views. For example, most respondents were supported by another person to complete the survey, in most cases an SDF peer researcher. Respondents may have adjusted their responses based on what they felt the peer researcher might prefer to hear.

We aimed to mitigate against the risk of response bias by carefully wording the questions and response options in such a way that both positive and negative views were presented as equally acceptable responses. More specifically, we were mindful to ensure that more negative views were not presented as less acceptable.

For example, we avoided binary yes-no questions, which have a higher risk of response bias. Respondents were, for example, asked how often they had experienced stigma, as opposed to whether they had experienced stigma.

We did not ask whether respondents felt support from services was now better than two years ago. We asked whether they felt support from services was now better or worse than two years ago. We also provided a range of response options (also including, for example, 'a little better' and 'a little worse') rather than presenting this as a yes-no question.

We asked responded whether they agreed or disagreed with statements in relation to their most recent ADRS, rather than only asking whether they agreed. We included statements that were worded positively (e.g. I was listened to) and statements that were worded negatively (e.g. I felt judged). We again provided a range of response options (also including, for example, 'rather agree' and 'rather disagree').

All (relevant) survey questions also gave respondents the opportunity to respond that they were not sure or preferred not to answer the question.

Free text comments may not reflect verbatim quotes

The language recorded as free text comments, by the SDF peer researchers or others supporting survey completion, may not reflect verbatim quotes.

Structure of the report

Part 1 presents the characteristics of survey respondents.

Parts 2 and 3 explores how the accessibility and quality of care is currently perceived. Part 2 looks at the treatment and care options individuals have received (e.g. OST or residential rehab), and any unmet needs. Part 3 looks at respondents' experience of trying to access support, including from their local ADRS (e.g. did they feel listened to?). Part 2 and 3 relate to the second of the **Aims of the survey**.

Part 4 explores whether the support from services is perceived as better or worse compared to two years ago. This relates to the first of the **Aims of the survey**.

The final section presents the conclusions and considerations for policy.

Part 1. Respondent characteristics

Total number of responses

In total, 494 responses were received; 381 of these responses included a free text response to one or more of the open questions.

All survey participants explicitly confirmed, in response to the initial eligibility question, that they had current or past experience of using drugs. All survey respondents also confirmed that, in the last 12 months, they had had support needs relating to their current or past experience of using of drugs.

Responses by data collection method

Only four of the 494 responses (less than 1%) were collected via paper copies returned to PHS via the post. The remaining responses were entered online.

The bulk of responses (419 or 85%) were entered online with the help of an SDF peer research interviewer. A small number of respondents (60 or 12%) indicated that they had completed the questionnaire on their own. This includes the four individuals whose paper copies arrived via the post. The remaining respondents were supported by a worker from their local ADRS (8 responses or 1.6%) or by a friend or family member (7 responses or 1.4%).

Responses by ADP area

Responses were received from 27 of 30 ADP areas (**Table 2**). A total of 87 responses (18%) were received from rural areas. The target quote of at least 20% of respondents from rural areas was narrowly missed.

Table 2. Responses by ADP area (n = 471)

ADP area	Number	ADP area	Number
Aberdeen City	20	Inverclyde	13
Aberdeenshire	8	Midlothian and East Lothian	14
Angus	6	Moray	6
Argyll and Bute	13	North Ayrshire	17
Clackmannanshire and Stirling	30	North Lanarkshire	26
Dumfries and Galloway	13	Orkney	0
Dundee	30	Perth and Kinross	13
East Ayrshire	18	Renfrewshire	6
East Dunbartonshire	13	Scottish Borders	19
East Renfrewshire	0	Shetland	0
Edinburgh	30	South Ayrshire	15
Falkirk	16	South Lanarkshire	23
Fife	32	West Dunbartonshire	8
Glasgow City	57	West Lothian	10
Highland	12	Western Isles	3

Responses by gender, age and ethnicity

Two thirds (67%) of respondents (n = 470) were male and one third (32%) were female. Two respondents ticked the 'other' response option, and two respondents preferred not to report their gender. The target quota of at least 20% female respondents was achieved.

Three quarters (76%) of respondents (n = 471) were aged between 30 and 54. Just fewer than 5% (22 respondents) were under 25.

Almost all (97%) respondents (n = 469) described their ethnicity as white.

Responses by housing and employment situation

Two in three (66%) respondents (n = 468) lived in a property they rented. Just over one in five (22%) were homeless, staying in temporary accommodation such as with friends or in a hostel (19%) or being roofless (3%). The target quota of at least 20% of respondents in insecure housing was achieved.

Half (51%) of respondents (n = 469) were unemployed and four in ten (41%) were inactive, because of a long-term condition or disability (37%) or because they were retired (2%) or in education (2%). Only 29 respondents (6%) were in employment or self-employed and 24 respondents (5%) ticked the 'other' response option. These percentages add to more than 100% because respondents could tick more than one employment status.

Quality of life and co-morbidities

One in three (32%) respondents (n = 470) reported their quality of life as excellent (6%) or good (26%). A slightly lower proportion (27%) reported their quality of life as poor (16%) or very poor (11%). The remaining respondents felt that their quality of life was fair (39%) or were not sure or preferred not to say (3%).

Just over three in four (77%) respondents (n = 457) reported mental ill-health. Three in ten (31%) reported a mobility impairment. Respondents also reported visual (16%) and hearing (11%) impairments. Just over one in ten (12%) reported a learning difficulty. These percentages add to more than 100% because respondents could tick more than one impairment.

Responses by pattern of substance use

Drug categories currently experienced as a problem

Respondents were most likely to report a problem with stimulants: this was the case for half (49%) of respondents (**Table 3**). A large number of respondents also reported problems with cannabinoids (37%), benzodiazepines (36%) or opioids (35%). These percentages add to more than 100% because respondents could tick more than one drug category.

Table 3. Responses by drugs currently causing problems (n = 437)

Drug category	Number	Percentage
Stimulants	216	49%
Cannabinoids	162	37%
Benzodiazepines and hypnotics	157	36%
Opioids	152	35%
Gabapentinoids	74	17%
Empathogens	30	7%
Psychedelics	30	7%
Dissociatives	27	6%
Over the counter medications	24	5%
Synthetic cannabinoids	20	5%
New (or novel) Psychoactive Substances	19	4%
Solvents / inhalants	13	3%
I prefer not to say	72	16%

Drug category experienced as the main problem

When asked to choose the one drug category that currently caused the most problems, respondents (n = 443) were again most likely to point to stimulants (36%).

The picture relating to cannabinoids, benzodiazepines and opioids changes, however, when respondents were asked to choose only one drug category. When free to tick all relevant drug categories, similar proportions of respondents reported a problem with cannabinoids, benzodiazepines and opioids (35%-37%, see **Table 3**). When asked to tick only the most problematic category, only one in ten (11%) identified cannabinoids as the drug category causing most problems. In comparison, opioids were identified as the drug category causing most problems almost twice as often, by two in ten (19%) respondents. Benzodiazepines were identified as the drug category causing the most problems by 14% of respondents.

Number of drug categories causing difficulty

Just over four in ten (44%) respondents reported problems with just one drug category (**Table 4**). This drug category was most likely to be stimulants. One in five (21%) reported problems with two drugs. The remaining one in three (34%) reported problems with three or more drugs.

Table 4. Number of drugs causing problems (n = 365)

Drugs	Number	Percentages
1 drug only, of which:	**162**	**44%**
• Stimulants	71	20%
• Cannabinoids	30	8%
• Opioids	30	8%
• Benzodiazepines	21	6%
• Other drugs	10	3%
2 drugs, of which:	**78**	**21%**
• Stimulants and cannabinoids	18	5%
• Stimulants and opioids	11	3%
• Benzodiazepines and opioids	10	3%
• Stimulants and benzodiazepines	9	2%
• Cannabinoids and benzodiazepines	9	2%
• Cannabinoids and opioids	9	2%
• Other combination	12	3%
3 drugs	54	15%
4 drugs	29	8%
More than 4 drugs	42	12%
All	365	100%

History of problems with drugs

Three in four (75%) respondents (n = 465) reported that they had had a problem with their use of drugs for more than 10 years. Only 6% had had a problem with drugs for two years or less. Only 1% had had a problem with their use of drugs for less than a year.

Two in three (65%) respondents (n = 462) had used drugs within the last month. Half (50%) had used drugs within the last week. A relatively small group (15%) had last used drugs longer than six months ago. This last group was considered as being in recovery for the purpose of subgroup analysis.

Problem with alcohol in last 12 months

Just over four in ten (43%) respondents (n = 465) reported a problem with alcohol use, in addition to their problem with drug use, in the last 12 months.

How representative or unrepresentative are the survey responses?

We cannot answer the question how representative (or unrepresentative) the survey responses are of the target population. This is because there are no detailed data on the exact composition of this population (i.e. all individuals in Scotland who have experience of using drugs and who, in the last 12 months, have needed support). We can, however, benchmark the characteristics of survey respondents against the characteristics of:

- Individuals who had their initial assessment for specialist drug and alcohol treatment recorded on **DAISy in financial year 2023/24**
- Individuals who participated in the **2022-2023 NESI survey**.

Table 5 allows us to cautiously conclude that the PHS lived experience survey has succeeded in also reaching individuals facing more complex needs. For example, **Table 5** demonstrates that respondent characteristics in the PHS lived experience survey are broadly similar to the respondent characteristics in the NESI survey, despite the NESI survey targeting a higher-risk group: individuals with experience of injecting drugs. In the PHS survey 22% report homelessness, compared to 6% in the DAISy database. In addition, only three in four (74%) respondents to the PHS lived experience survey had engaged with their local ADRS in the last 12 months. This means that at least some individuals currently not engaging with ADRS services took part in the survey.

Table 5. Comparison respondent characteristics to DAISy and NESI

Respondent characteristics	PHS lived experience survey	DAISy database	NESI survey
Female	32%	32%	30%
Aged 25-54	83%	72%	89%
White	97%	72%	-
Living in a rural area	18%	18%	-
Homeless	22%	6%	30%
Problem with drugs for more than 10 years	75%	-	72%

Note: There is a large proportion (27%) of DAISy records where the ethnicity is unknown. The NESI survey asks about homelessness in the last six months; the PHS lived experience survey asks about respondents' current housing situation. The NESI survey asks about time since onset of injecting; the PHS lived experience survey asks how long respondents have had a problem with drugs.

Conversely, limitations in the PHS lived experience survey include poor reach of:

- Young people – just fewer than 5% of the PHS lived experience survey respondents were under 25 (compared to 9% in the DAISy database)
- Ethnicities other than white – 97% described their ethnicity as white
- Individuals in prison – only 1% described their housing situation as being in prison or a youth offenders' institute (compared to 6% in the DAISy database).

The target population included those who were not currently using drugs. It is not possible to know, based on the DAISy or NESI datasets, how representative the survey responses are for the population of individuals in recovery. For the purpose of this report, being in recovery was defined as not having used illicit drugs in the last six months. This information is not available through DAISy or NESI. DAISy contains some partially relevant information. DAISy reports on use of illicit drugs within the last month (85% in 2023/24). In the 2024 PHS lived experience survey, this percentage was lower (65%). This suggests that the PHS lived experience survey has succeeded in also reaching individuals whose experience of using drugs was less recent.

Finally, because of the recruitment channels used, it is likely that those in contact with their local ADRS or peer support groups are overrepresented compared to the target population.

Part 2. Treatment and care received

This chapter explores whether respondents have needed, and have been able to access, a number of specific treatment and care options. It looks at:

- The different treatment and care options received by respondents in the last 12 months, with a more detailed focus on four specific treatment options (OST, detoxification and residential rehab, and naloxone)
- Unmet needs for different treatment and care options as experienced by respondents in the last 12 months
- A measure of total demand for different treatment and care options in the last 12 months, calculated by combining data on the treatment and care options received and unmet need for those same treatment and care options.

Treatment received in the last 12 months

Respondents were presented with a list of ten possible treatment and care options and were asked to tick all those they had received in the last 12 months (**Table 6**). A more detailed description of the ten treatment and care options can be found in **Appendix 3**. For example, the questionnaire described peer support as recovery communities, recovery groups or cafés and networks for people who use drugs.

Table 6. Treatment and care received in the last 12 months (n = 473)

Treatment and care	Number	Percentage
Peer support	289	61%
A naloxone kit	265	56%
Counselling or mental health support, one-on-one	224	47%
Other harm reduction support [other than naloxone]	167	35%
MAT / OST	165	35%
Housing support	155	33%

Treatment and care	Number	Percentage
Counselling or mental health support, in a group	94	20%
Detoxification	73	15%
Employment support	58	12%
Residential rehab	56	12%
I have not received any treatment or support	19	4%

Note: The total adds to more than 473: respondents could tick more than one response option. See **Appendix 3.** Treatment and care options for a full description of the ten treatment and care options.

The most commonly reported treatment and care options received were peer support (61%) and a naloxone kit (56%). Just fewer than half (47%) had received one-on-one counselling or mental health support. Just more than one in three (35%) had received OST. Access to OST was higher among those who reported a problem with opioids. In this subgroup (n = 150), 57% had received OST. Just over one in ten respondents had accessed detoxification (15%) or residential rehab (12%).

Differences by gender and pattern of drug use

Female respondents (n = 152) were less likely to have received a naloxone kit (49% compared to 59% of male respondents), other harm reduction support (28% compared to 39%), or employment support (8% compared to 15%).

Respondents in recovery (n = 70) were less likely to have received a naloxone kit (49% compared to 61% of those not in recovery) or other harm reduction support (16% compared to 41%).

Ease of access to OST

Wait between request for OST and first dose of OST

Those who had received OST in the last 12 months, were asked how long they had to wait before they received the first dose of their medication (**Table 7**). Four in ten

(41%) respondents got their first dose on the same day (23%) or the day after (18%) they asked for their OST prescription. In total, just fewer than seven in ten (68%) got the first dose of their medication within a week of asking for their prescription. Just over one in ten (12%) waited longer than a month.

Table 7. Wait between request for OST and first dose of OST

Wait	Number	Percentage
On the same day I asked for a prescription	38	23%
The next day	30	18%
Within a week	43	26%
Within two weeks	13	8%
Within a month	8	5%
I waited longer than a month	20	12%
I never asked for a prescription	2	1%
I am not sure / I prefer not to say	10	6%
All	164	100%

Choice of OST medication

Just over six in ten (63%) respondents (n = 164) got the medication they asked for when they asked for an OST prescription. Just over three in ten (32%) did not: 19% did not realise they had a choice of OST medication and 13% realised they had a choice but did not get the medication they asked for.

A number of free text responses related to choice of OST medication, or lack thereof.

> I just started the Buvidal injection and, after that, they're sorting out a detox and rehab for me, so I can’t fault my drug treatment team. (Respondent 190)
>
> [I] wanted to reduce methadone and change to buprenorphine but wasn't being allowed by [the] service. (Respondent 357)

> … I never knew I had a choice about my methadone treatment when I re-accessed it, they just put me on that. How am I meant to know I have choices if I am not told? … (Respondent 277)

Ease of access to detox and rehab

Just fewer than six in ten (56%) respondents who had accessed detoxification (n = 73) reported that it has been easy to get into detox. Just fewer than four in ten (36%) described this as difficult.

Just fewer than half (47%) of those who had accessed rehab (n = 55) had found it easy to get into rehab. A similar proportion (45%) had found it difficult.

The free text responses reflected positive and negative experiences of trying to access residential rehab.

> [I] got into rehab fairly quickly earlier this year following a relapse after [a] traumatic incident in [my] family. [It] had never been offered before, but it has been life changing. (Respondent 78)
>
> I felt I had to fight to ask for rehab and I was told 'no' from ADRS because: 'you're coming out to the same circumstances, so you would need more willpower'. (Respondent 225)
>
> I was pleading with my drug worker to get me into a rehab centre… He totally dismissed me… (Respondent 189)

Use of naloxone kits

Overall, just fewer than six in ten (56%) respondents had received a naloxone kit in the last 12 months (see **Table 6**). Of those (n = 263), 38% reported that they had already used their naloxone kit.

Female respondents (n = 74) were as likely as male respondents to have already used their naloxone kit. They were, nevertheless, less likely to have received a kit (49% compared to 59%), as mentioned above (**Differences by gender and pattern of drug use**).

A similar picture emerges when looking at opioid use. Although naloxone acts to temporarily reverse the effects of opioid overdose, there was no relationship between having a problem with opioids and using a naloxone kit. This may be because respondents used the kit to help someone else. Those not reporting a problem with opioids (n = 107) were as likely as those reporting a problem with opioids to have already used their naloxone kit. They were, nevertheless, less likely to have received a kit (50% compared to 65% among those who reported a problem with opioids).

Context: other data sources about access to treatment

For some of the treatment and care options, other data sources are available about the number of individuals accessing those treatments (**Table 8**).

Table 8. Individuals receiving treatment in last 12 months

Treatment	PHS lived experience survey	Other data sources
A naloxone kit	56% (65%)	**NESI survey**: 69% had received a kit in 2022/23 **PHS annual naloxone report**: 28,689 kits issued in 2022/23
MAT / OST	35% (57%)	**PHS prescribing data**: 28,537 people estimated to have received OST in 2023/24
Residential rehab	12%	**Figure 8 survey**: 23% had accessed rehab in the last 24 months **PHS aggregate residential rehab placements data**: 989 started a placement for drug use or co-dependency in 2022/23

Note: The percentage in brackets presents the results when only including those who reported a problem with opioids. All data relate to a 12-month period, with the exception of the Figure 8 survey data, which relate to a 24-month period.

The data from the PHS lived experience survey are broadly compatible with those other data sources when it comes to access to naloxone and OST. This is not the case for residential rehab. Only 989 individuals started a residential rehab placement for drugs or co-dependency (i.e. drugs and alcohol) in Scotland in 2022/23. This likely only constitutes 1-2% of the total number of individuals in Scotland with problem drug use (see page 38 of the **2023 PHS baseline residential rehab evaluation report**). This is a different order of magnitude than the 12% reported in the lived experience survey.

There probably is a degree of selection bias in the survey towards those in contact with their local ADRS or peer support groups. This bias may be a bigger factor in the question about access to rehab than the questions about access to naloxone or OST: awareness of rehab may depend more heavily on being in contact with services or peer support groups.

Unmet needs in the last 12 months

Respondents were presented with a list of 14 possible treatment and care options and asked to tick all the options they would have liked to receive in the last 12 months but were not able to access (**Table 9**). In the rest of this section, and throughout the report, we use 'unmet need' to refer to the responses to this question.

Access to counselling or mental health support, one-on-one, emerged as the biggest unmet support need: almost half (47%) of respondents reported that they would have liked to access this in the last 12 months, but had been unable to do so. About three in ten reported residential rehab (29%) and treatment for drugs other than opioids (28%) as unmet support needs. About one in four identified housing support (25%) and access to drug checking services (23%) as an unmet support need.

Table 9. Unmet needs in the last 12 months (n = 414)

Treatment and care	Number	Percentage
Counselling or mental health support, one-on-one	193	47%
Residential rehab	121	29%
Treatment for drugs other than opioids	114	28%
Housing support	105	25%
Access to drug checking services	96	23%
Counselling or mental health support, in a group	89	21%
Detoxification	64	15%
Access to a safer drug consumption facility	56	14%
Peer support	54	13%
Employment support	54	13%
Other harm reduction support [other than naloxone]	38	9%
MAT / OST	26	6%
Heroin-assisted treatment	22	5%
A naloxone kit	13	3%

Note: The total adds to more than 414: respondents could tick more than one response option. See **Appendix 3.** Treatment and care options for a more detailed description of, for example, 'peer support' and 'other harm reduction support'.

Exploring unmet need for OST in more detail

We might have expected unmet need for OST to be concentrated in the group of respondents who reported a problem with opioids but who had not received OST in the last 12 months (n = 50). However, only 2 of these 50 respondents (4%) reported an unmet OST need. The remaining 48 respondents (96%), despite reporting a problem with opioids, did not report that they wished to access this support.

Instead, unmet need for OST was concentrated in the group of respondents who had a problem with opioids but who had received OST in the last 12 months (n = 76). One in five (20%) of these 76 respondents reported an unmet need for OST.

Differences by gender, housing situation and rural vs urban area

Female respondents (n = 135) were more likely to report peer support as an unmet support need (18% compared to 10% of male respondents).

Respondents in insecure housing (n = 92) were more likely to report unmet needs for housing support (38% compared to 22% of those in secure housing) and for residential rehab (41% compared to 25%).

Residents from rural areas (n = 75) reported higher levels of unmet need in relation to OST, naloxone and other harm reduction support, peer support and employment support (**Table 10**). For example, respondents in rural areas were seven times more likely to report that they would have liked to access a naloxone kit but had not been able to do so. However, even in rural areas, unmet need for a naloxone kit remained relatively low (11%).

Table 10. Unmet needs rural and urban respondents

Treatment and care option	Rural (n = 75)	Urban (n = 333)	Ratio
A naloxone kit	11%	2%	7.10
Employment support	25%	10%	2.56
MAT / OST	12%	5%	2.35
Peer support	24%	11%	2.28
Other harm reduction support	16%	8%	2.05

Note: See **Appendix 3.** Treatment and care options for a more detailed description of 'peer support' and 'other harm reduction support'.

Differences by pattern of drug use

The drug categories respondents experienced a problem with did not tend to affect the nature of their unmet needs. The only exceptions were the four treatment options explicitly targeting those with, or those without, a problem with opioids (**Table 11**).

Table 11. Unmet needs by reporting a problem with opioids or not

Unmet need	Problem with opioids (n = 127)	No problem with opioids (n = 281)
MAT / OST	13%	3%
Heroin-assisted treatment	13%	2%
A naloxone kit	7%	1%
Treatment for drugs other than opioids	20%	31%

Respondents in recovery (n = 59) were more likely to report an unmet need in relation to mental health support in a group, peer support and naloxone and other harm reduction support (**Table 12**).

Table 12. Unmet needs respondents in recovery and not in recovery

Treatment and care option	In recovery (n = 59)	Not in recovery (n = 268)
Counselling or mental health support, in a group	34%	18%
Peer support	20%	11%
Other harm reduction support	15%	9%
A naloxone kit	7%	2%

Note: For the purpose of the subgroup analysis, not having used illicit drugs within the last six months was interpreted as being in recovery. Having used illicit drugs within the last month was interpreted as not being in recovery. See **Appendix 3.** Treatment and care options for a more detailed description of 'peer support' and 'other harm reduction support'.

Free text responses about unmet need

Several of the unmet needs included in **Table 9** featured in the free text responses.

Unmet mental health support needs featured most prominently. Many of the free text comments related to gaps in the support offer from specialist mental health services. Respondents referenced, for example, long waiting times or eligibility criteria which stop individuals who use substances from accessing specialist mental health services. They saw this as perverse when their substance use was in part driven by their mental ill-health.

Others referenced the need for better trauma-informed support across services and organisations. There was also a recurring theme of human connection. Respondents expressed a need to feel listened to. They talked about the positive impact when they felt listened to or felt connected in their interaction with staff or, more commonly, in peer support community and recovery groups. At times, requests for mental health support reflected the need for better trauma-informed support or for human connection, instead of, or alongside, a need for professional mental health input.

> … trying to access [a] psychiatrist [or] psychology when actively using [drugs] is still a no go, which is a shame as that is the reason I am using substances. (Respondent 105)
>
> … The mental health side is very lacking, the long waiting list means that people still struggle with their mental health, trauma, whilst dealing with their addiction. (Respondent 22)
>
> I think trauma support is massively missing from general support – it isn't looked at… we all have trauma… (Respondent 376)
>
> I don't feel I get listened to, especially when it comes to mental health… now that I have been going to the [third sector peer support] group I feel heard, and they have been so supportive, and this is what has been missing. (Respondent 102)

Unmet needs relating to treatment for non-opioid substance use also featured prominently in the free text responses. Housing support, residential rehab, recovery support and relapse prevention and drug checking services also featured, if less frequently.

> Also, for non-opiates there is no support…. They do not care for speaking about benzos [or] cocaine, as it is not seen as serious and that is my issue. Hence, I have had to go and find my own supports with the community. (Respondent 225)
>
> [I am] really struggling at the moment. [I have] had very limited support since coming out of prison last month. [I have] not been able to access housing, so [am] sleeping on the streets and struggling with getting food… (Respondent 218)
>
> There is no care around relapse prevention – nobody wants to know once you have stopped using. They do not care about mental health. They do not care about recovery. (Respondent 101)
>
> I think just having other options like drug checking [or] supervised injection would be so useful, especially for me as I am using cocaine. (Respondent 17)

Total demand for treatment and care

Combining the data on the treatment and care options respondents received in the last 12 months with the data on the treatment and care options they would have liked to access but were unable to[i], can provide an indication of total levels of demand for different treatment and care options (**Table 13**).

---

[i] Those who had accessed a certain treatment option and also reported it as an unmet need were only counted once.

Table 13. Total demand for treatment and care options (n = 411)

Treatment and care	Number	Percentage
Counselling or mental health support, one-on-one	334	81%
Peer support	276	67%
A naloxone kit	239	58%
Housing support	209	51%
Other harm reduction	174	42%
Counselling or mental health support, in group	163	40%
Residential rehab	158	38%
MAT / OST	149	36%
Detoxification	126	31%
Employment support	95	23%

Note: See **Appendix 3.** Treatment and care options for a more detailed description of, for example, 'peer support' and 'other harm reduction support'.

Total demand was highest for one-on-one mental health support, covering the vast majority of respondents (81%). Total demand was also high for peer support, covering two in three (67%) respondents. Total demand covered more than half of respondents for naloxone (58%) and housing support (51%). Taken across the survey population, total demand for OST stood at 36%. Only including respondents who reported a problem with opioids (n = 126) suggested that total demand for OST stood higher, at 62%.

Summary: support received, unmet need, total demand

Table 14 brings together the data from **Table 6, Table 9** and **Table 13** on support received, unmet need and total demand across ten treatment and care options.

Table 14. Summary – support received, unmet need, total demand

Treatment and care options	Support received (n = 473)	Unmet need (n = 414)	Total demand (n = 411)
Mental health support, one-on-one	47%	47%	81%
Peer support	61%	13%	67%
A naloxone kit	56%	3%	58%
Housing support	33%	25%	51%
Other harm reduction	35%	9%	42%
Mental health support, in group	20%	21%	40%
Residential rehab	12%	29%	38%
MAT / OST	35%	6%	36%
Detoxification	15%	15%	31%
Employment support	12%	13%	23%

Note: The 'total demand' column tends to be lower than the sum of the 'support received' and 'unmet need' columns. This is because respondents could report that they had accessed a certain treatment option and still report it as an unmet need. Those respondents were only counted once to calculate total demand. **Table 14** does not include four treatment options which were only included in the unmet need question: drug checking, safer drug consumption facilities, heroin-assisted treatment and treatment for drugs other than opioids. See **Appendix 3.** Treatment and care options for a more detailed description of, for example, 'peer support' and 'other harm reduction support'.

It is worth nothing that:

- There are a number of instances where high levels of total demand coincide with high levels of unmet need. This is the case for one-on-one mental health support and, at slightly lower levels, housing support.
- There are a number of instances where high levels of total demand coincide with low levels of unmet need. This is for example the case for naloxone and

other harm reduction support. This is also the case for OST when only including respondents who report a problem with opioids, where total demand stands at 62% and unmet need at 13%. Peer support similarly combines high levels of total demand with relatively low levels of unmet need.

- There is one treatment option, residential rehab, where unmet need constitutes the bulk of total demand (76%).

Part 3. Experience of trying to access support

This chapter looks at respondents' experience of trying to access support:

- Their experience of trying to access support in the last 12 months from one specific support service, their local ADRS
- How supportive they feel a number of different statutory services are
- How supportive they feel family and friends, and mutual aid and other recovery groups are
- Whether, overall, respondents feel they are getting the support they need.

Experience of accessing ADRS support

Number of respondents receiving ADRS support

Three in four (74%) respondents had received support from their local ADRS in the last 12 months.

Respondents who reported a problem with opioids (n = 151) were more likely to have received ADRS support in the last 12 months (86% compared to 65% of respondents not reporting a problem with opioids).

Respondents in recovery (n = 70) were less likely to have received ADRS support in the last 12 months (63% compared to 78% of respondents not in recovery).

Frequency of contact with ADRS

Just more than four in ten (42%) respondents reported that they were currently seen at least every two weeks by their local ADRS (**Table 15**).

Table 15. How often are you currently seen by your local ADRS?

Frequency	Number	Percentage
Once a week	84	23%
Every two weeks	68	19%
Once a month	126	35%
Every two months	21	6%
There is more than two months between appointments	40	11%
I am not sure / I prefer not to say	19	5%
All	358	100%

Do respondents with higher or more complex needs report a higher frequency of ADRS appointments?

We used a number of proxy indicators to explore whether those with higher or more complex needs were seen more frequently by their local ADRS.

Respondents who also reported a problem with alcohol, alongside their problem with drugs (n = 141), were more likely to be currently seen at least every two weeks by their local ADRS (49% compared to 37% of those reporting no problem with alcohol).

Respondents who had used drugs within the last week (n = 178), those reporting a problem with more than one drug (n = 155), those in insecure housing (n = 77) and those reporting mental ill-health (n = 266) were not more likely to report that they were currently seen at least every two weeks.

Overall rating of ADRS care

Overall, six in ten (60%) respondents rated the care they had received from their local ADRS in the last 12 months as excellent or good. Two in ten (19%) rated the ADRS care they had received as poor or very poor (**Table 16**).

Table 16. Overall rating of ADRS care in the last 12 months

Overall rating of ADRS care	Number	Percentage
Excellent	99	28%
Good	116	32%
Fair	67	19%
Poor	33	9%
Very poor	35	10%
I am not sure / I prefer not to say	8	2%
All	358	100%

Differences by gender and housing situation

Female respondents (n = 115) were less likely to rate ADRS care as excellent or good (50% compared to 64% of male respondents).

Respondents in insecure housing (n = 77) were also less likely to provide a positive rating (44% compared to 62% of respondents in secure housing).

Differences by pattern of drug use

Respondents who reported stimulants as their main problem drug (n = 117) were less likely to rate ADRS care as excellent or good (49% compared to 65% of those reporting another drug category as the main problem).

Respondents who reported a problem with benzodiazepines (n = 121) were also less likely to rate ADRS care as excellent or good (50% compared to 65% of those not reporting a problem with benzodiazepines).

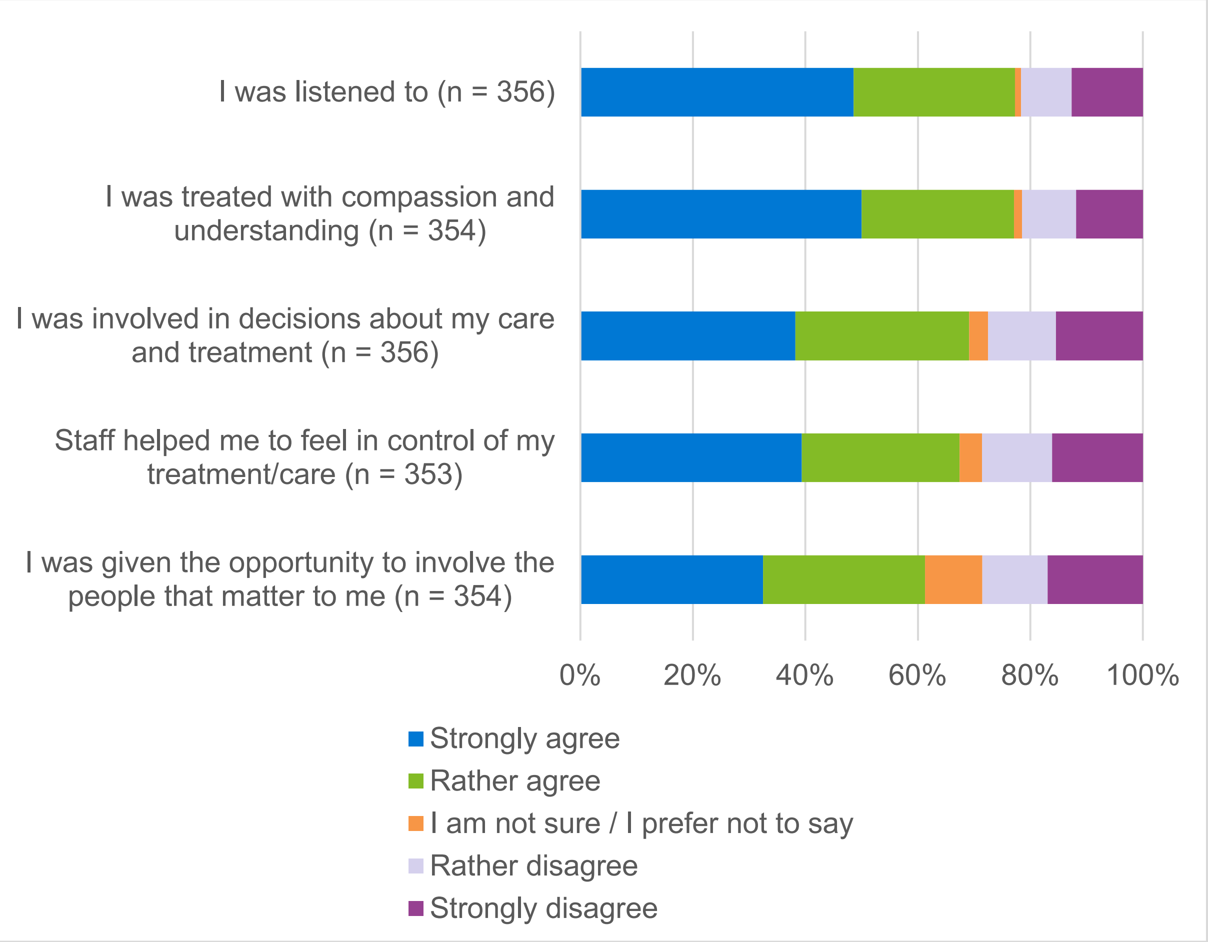
Differences by frequency of contact with ADRS

There was also a relationship between the frequency of ADRS appointments and respondents' rating of ADRS care. Respondents who were currently only seen every two months or less frequently (n = 61), were less likely to provide a rating of excellent or good than those seen at least every two weeks (28% compared to 78%). Among those who were currently seen once a month, 60% provided a positive rating.

Experience the last time respondents accessed ADRS support

Respondents were presented with five positive and five negative statements about their experience of the support offer the last time they accessed ADRS services. They were asked to indicate whether they agreed or disagreed with the statements (**Figure 2** and **Figure** 3).

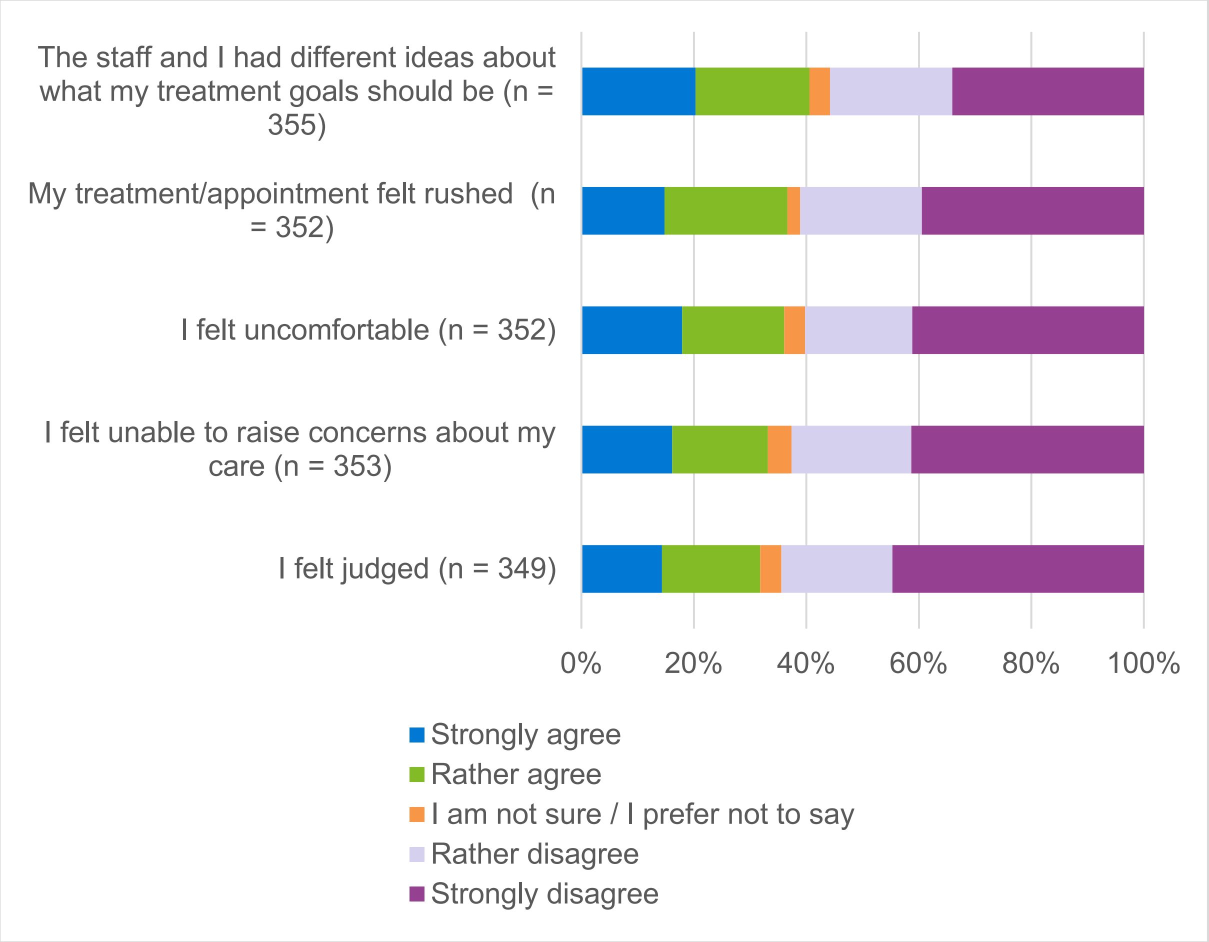
Figure 2. Latest ADRS support experience – positive statements



For each of the five positive statements (**Figure 2**), at least six in ten respondents agreed with the statement. For example, just fewer than eight in ten (77%) agreed that they were listened to and were treated with compassion and understanding the last time they went to their local ADRS for support. About three in ten did not agree that they had been involved in decisions about their care and treatment (28%), that staff had helped them feel in control of their treatment and care (29%) or that they were given the opportunity to involve the people that mattered to them (29%).

For each of the five negative statements (**Figure 3**), substantial proportions agreed with the statement. Respondents were most likely to agree with the statement that the staff and they had different ideas about treatment goals. This was the case for four in ten (41%). More than three in ten felt uncomfortable (36%) or judged (32%).

Figure 3. Latest ADRS support experience – negative statements



Differences by gender and housing situation

Female respondents (n = 113) were less likely to agree with the positive statements and more likely to agree with the negative statements. For example, just fewer than six in ten (57%) female respondents agreed that staff helped them feel in control of their treatment and care (compared to 73% of male respondents). Half (50%) of female respondents agreed that their treatment or appointment had felt rushed (compared to 31% of male respondents).

Respondents in insecure housing (n = 77) were more likely to agree with some of the negative statements. For example, they were more likely to agree that they had felt judged (43% compared to 29% of those in secure housing).

Free text responses about the support experience

The free text responses echo the variety in the support experience reflected in **Figure 2** and**Figure** 3. Not all comments explicitly referenced ADRS services, but many related to the ADRS support experience.

> Overall brilliant. Staff are nice and listen to me – they give you time. They have compassion and [are] considerate. (Respondent 242)
>
> My worker doesn't listen to me. [It's as] simple as that. (Respondent 230)

Several of the free text comments suggested that respondents saw a link between the support they receive and the pressures frontline staff experience. One respondent explicitly referenced paperwork as a factor impacting on the support experience.

> Staff do try hard to give care to their patients but are under immense pressure therefore the level of care has been affected. (Respondent 130)
>
> Accessing ADRS you can see the tiredness [and the] strain of funding being crap and no care in the team [and] no morale for anyone. (Respondent 225)
>
> I know they can't help it, but staff changes are constant. (Respondent 158)
>
> They are understaffed and you can never get through to them… (Respondent 250)

> Too much paperwork and not enough listening and actively [helping]. (Respondent 314)

Stigma when accessing ADRS support

Half (49%) of respondents reported that they had never, in the last 12 months, experienced stigma or discrimination from their local ADRS. Half (49%) reported that they had. Just fewer than two in ten (16%) reported that they had experienced this always or often (**Table 17**).

Table 17. Stigma or discrimination from ADRS in the last 12 months

How often?	Number	Percentage
Always	24	7%
Often	32	9%
Sometimes	70	20%
Rarely	49	14%
Never	174	49%
I am not sure / I prefer not to say	8	2%
All	357	100%

Respondents who reported a learning disability (n = 40) were more likely to report that they had always of often, in the last 12 months, experienced stigma or discrimination from their local ADRS (35% compared to 14% of those who did not report a learning disability).

Stigma also featured in the free text responses. A number of respondents reported feeling judged, dismissed, intimidated or looked down upon. There were examples of stigma across different categories of statutory support providers, including but not limited to ADRS.

> I feel very dismissed. I regularly feel intimidated in the NHS addictions service… I often feel worse after interaction. (Respondent 355)
>
> … even picking up medication from the chemist most people are fine, but you do get judged and are really ashamed and people don't make it much better. (Respondent 93)
>
> Primary care has a lot of stigma and they don't understand the impact of addiction. (Respondent 359)

Quality of relationship with ADRS key worker

Just more than six in ten (62%) respondents described the quality of their relationship with their ADRS key worker as excellent or good. Almost four in ten (38%) rated the quality of this relationship as excellent. Just more than one in ten (14%) described the quality of their relationship with their key worker as poor or very poor. A small proportion (7%) of respondents reported that they did not have a key worker.

A recurring theme across the free text responses was that the quality of the relationship with staff was key to the support experience. This included but was not limited to the quality of relationships with ADRS staff.

> There is a huge difference between staff members, with some being really helpful and some really unhelpful in drug and alcohol services. (Respondent 267)
>
> Everything is worker-related. (Respondent 241)

Ease of accessing ADRS

Three in four (74%) respondents reported that it was easy to get to the building where local ADRS services are based. One in four (25%) reported this was difficult.

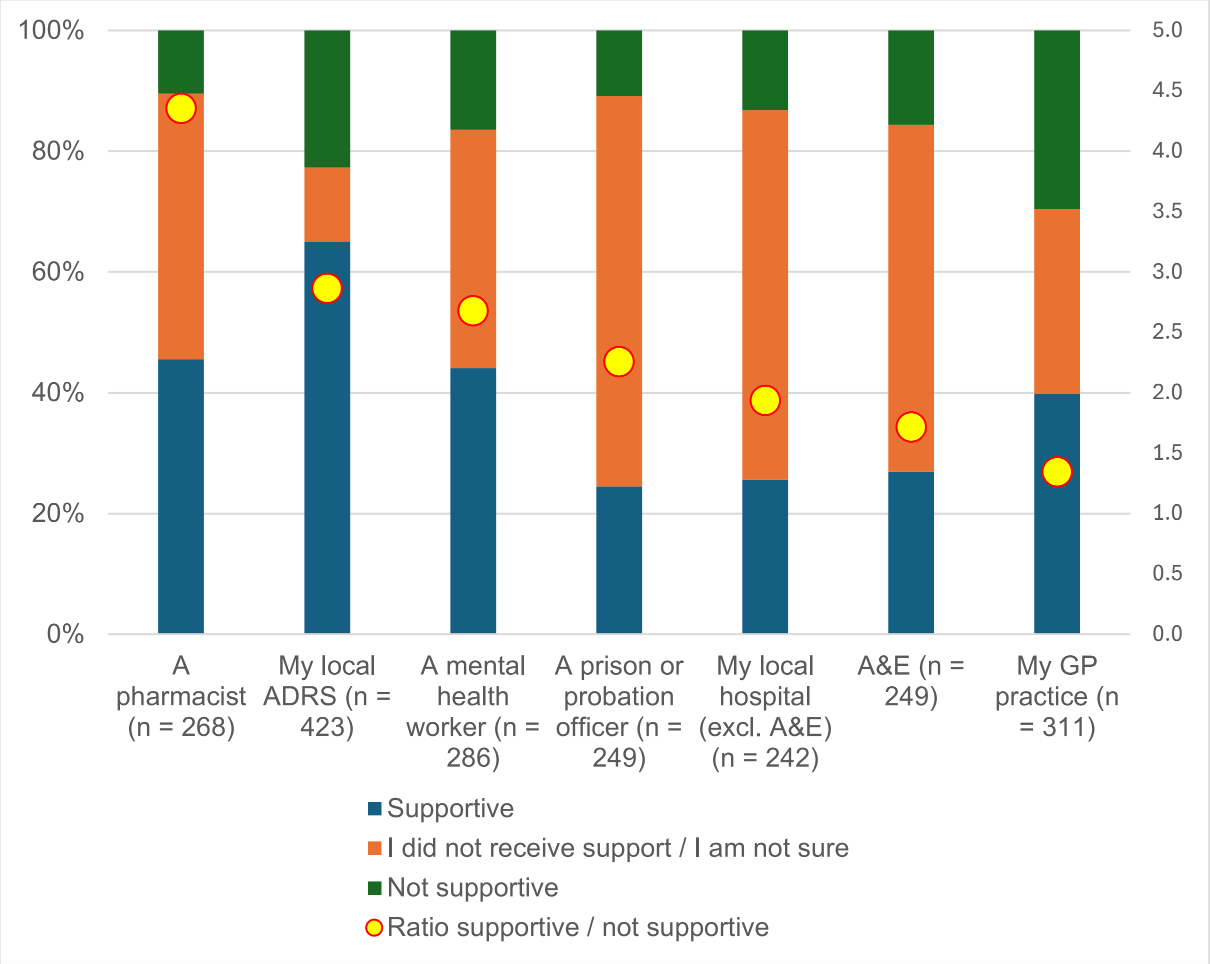
One in four (25%) respondents reported that it was easy to access their local ADRS out-of-hours. Half (51%) reported that this was difficult. A relatively large proportion, one in four (24%), reported that they were not sure or preferred not to say.

Which statutory services are experienced as supportive?

Respondents were presented with a list of statutory services and asked how supportive these different services had been (**Figure 4**).

The stacked bars in Figure 4 (with their blue, orange and green sections) represent the positive, 'I am not sure' and negative responses. The small yellow dots in Figure 4 represent the ratio of positive to negative responses. The value of those ratios is given on the right-hand side of the graph.

Figure 4. How supportive are different statutory services?



Pharmacists emerged as the statutory service which was most likely to have been experienced as supportive. Respondents were four (4.4) times more likely to describe their pharmacist as supportive than as not supportive: 46% described their pharmacist as supportive and 10% as not supportive.

Local ADRS services and mental health workers also scored relatively high. Respondents were almost three times more likely to describe their local ADRS services (2.9) or their mental health worker (2.7) as supportive than as not supportive. Just fewer than two in three (65%) described their local ADRS as supportive and just fewer than one in four (23%) described them as not supportive. Just fewer than half (44%) described their mental health worker as supportive and 16% as not supportive.

GP practices were less likely to be experienced as supportive. More respondents still described their GP practice as supportive (40%) than as not supportive (30%).

The free text responses echoed the variety in the statutory support experience, as presented in **Figure 4**. Across all categories of statutory support providers that were mentioned, there was at least one more positive and at least one more negative comment. GPs, pharmacists, social workers, prison and probation officers, ADRS and NHS services were all referenced both as having been supportive and as having been unsupportive.

> GP [was] really supportive after [me] being in hospital. I engage with them better than any other services, as they have known me so long. (Respondent 97)
>
> … GP [does] not want to seem to be involved in any sort of support when it comes to addiction… (Respondent 106)
>
> Really impressed with the social work support, on all matters such as housing, financial, clothing and food. (Respondent 69)
>
> Support from social work needs to be better – I feel it is forced support… (Respondent 36)

Support from family, friends and recovery groups

Respondents were also asked how supportive they felt family and friends, mutual aid groups and other recovery groups (such as for example recovery cafés) had been. These groups tended to be perceived as supportive (**Table 18**). The ratio of positive to negative responses was higher than the ratios for statutory services reported in **Figure 4**. For example, more than eight in ten (85%) felt that 'other recovery groups' had been supportive and only 1% felt that these groups had not been supportive.

Table 18. How supportive are family, friends and recovery groups?

Non-statutory stakeholder group	Supportive	Not supportive	Ratio
Family or friends	66%	7%	10
A mutual aid group	51%	6%	9
Other recovery [other than mutual aid]	85%	1%	59

Note: The percentages do not add to 100% because respondents were also able to tick the response option 'I did not receive support / I am not sure'. Other recovery was defined as, for example, recovery groups or cafés. A mutual aid group was defined as, for example, 12 Step Fellowships or SMART Recovery.

It is theoretically possible that these positive findings reflect a degree of bias. The vast majority of survey responses were collected via interviews conducted by SDF peer researchers, often in peer support settings. Respondents may, for example, have felt that describing recovery groups as 'unsupportive' was socially less acceptable. However, even among respondents who participated in the survey without SDF support (n = 51), 69% still felt that 'other recovery groups' had been supportive and only 2% felt that these groups had not been supportive.

The support from third sector and recovery groups was experienced positively by all respondents who commented on this support in a free text comment. This stood in contrast to the free text comments in relation to the statutory support experience, which were a mix of positive and less positive comments (**Which statutory services are experienced as supportive?**). Respondents at times explicitly contrasted a more positive support experience from third sector organisations with a less positive support experience from statutory services.

> [Name of recovery organisation] has been amazing for support and a safe space to speak and talk through emotions. (Respondent 134)
>
> The [name of ADRS] – it just feels like they do not care… I do get support from [name of worker at third sector organisation] who does outreach and always checks in on me. She is the only one that cares. (Respondent 221)

Perhaps related, across the free text responses, there was a recurring theme that there should be more individuals with experience of using drugs in statutory services, and more access to peer support.

> I think more folk with experience like mine with drugs, that knows how it feels to be in that way, is what will change the experiences in services. (Respondent 12)
>
> Peer support is invaluable as they can understand what I am going through much more and not just learnt out a book. There needs to be a peer available to see folk and support them to attend appointments and give outreach. (Respondent 357)

Overall experience of the support offer

Feeling informed about the available support

Respondents (n = 479) were asked how well informed they felt overall about the support available to them. Seven in ten (71%) respondents reported that they felt very well (27%) or quite well (44%) informed. Just fewer than three in ten (28%) felt not very (20%) or not at all (9%) informed.

In the free text responses, several respondents commented that they did not feel sufficiently informed about the treatment, care and support available to them.

> I'm unsure of what I am able to access treatment / support-wise… (Respondent 126)
>
> I would only like to add that I do not have much knowledge on services that are available. (Respondent 214)
>
> … The support works but you have to really find it... (Respondent 47)

Being able to access the support that is needed

Respondents (n = 477) were asked whether, overall, they were getting the support they needed. Just over half (52%) of respondents reported that they were getting all (19%) or most (32%) of the support they needed. One in three (33%) reported that they were getting some of the support they needed and 14% reported getting none of the support they needed. The remaining 1% were not sure or preferred not to say.

Differences by pattern of drug use and housing situation

Respondents who reported a problem with benzodiazepines (n = 155) were less likely to report they were getting all or most of the support they needed (42% compared to 52% among those not reporting a problem with benzodiazepines).

Respondents in insecure housing (n = 104) were also less likely to report that they were getting all or most of the support they needed (39% compared to 55% of respondents living in secure housing).

Differences by frequency of local ADRS appointments

Respondents who were currently only seen every two months, or less frequently, by their local ADRS (n = 61) were less likely to report that they were getting all or most of the support they needed (23% compared to 68% of those who were currently seen at least every two weeks). Among those who were currently seen once a month, 54% reported that they were getting all or most of the support they needed.

Part 4. Changes to the support offer over time

Is the support now better or worse than two years ago?

Survey participants (n = 476) were asked whether the support they were getting from services now was better or worse than the support they were getting from services two years ago. Just under one in five (17%) respondents were not receiving support two years ago and could not tell whether services had changed. Among the remaining 395 respondents, seven in ten (69%) felt that the support was now much or a little better than two years ago and two in ten (21%) felt that the support was now much or a little worse (**Table 19**).

Table 19. Support now compared to two years ago (n = 395)

Experience	Number	Percentage
Much better	125	32%
A little better	146	37%
A little worse	28	7%
Much worse	55	14%
I am not sure / I prefer not to say	41	10%
All	395	100%

Note: This analysis excludes the 81 respondents who reported that they were not receiving support two years ago and could not tell whether services had changed since then.

Why are things improving?

Those who felt that the support offer was improving were asked why they thought things were improving (**Table 20**). They were most likely to tick the response options that they were now getting support more quickly; were now treated with more respect by services; or were now seen more often by their support workers.

Table 20. Why do you think things are getting better? (n = 266)

Rationale	Number
I now get the support I need more quickly	106
I am now treated with more respect by services	100
I now get seen more often by my support worker(s)	89
I now have more choice when it comes to OST	56
It is now easier to involve my family and friends if I wish to do so	38
Staff are now more likely to consider rehab as a treatment option	27

Why are things getting worse?

Those who felt that the support offer was now much or a little worse were asked why they thought things were getting worse (**Table 21**). They were most likely to tick the response option that they now had to wait longer to get the support they needed; or were now seen less often by their support workers.

Table 21. Why do you think things are getting worse? (n = 82)

Rationale	Number
I now have to wait longer to get the support I need	44
I now get seen less often by my support worker(s)	39
I now have less choice in what treatment and support is offered to me	28
I now experience more stigma from staff	25
It is now harder to involve my family and friends	16

Differences by pattern of drug use and complexity of need

Respondents who reported a problem with opioids (n = 137) were more likely to report that the support they were getting from services now was better than two years ago (74% compared to 63% of those who did not report a problem with opioids).

Are respondents with higher or more complex needs less likely to report progress?

We used a number of proxy indicators to explore whether those with higher or more complex needs were less likely to report that the support from services now was better than two years ago.

Respondents who also reported a problem with alcohol, alongside their problem with drugs (n = 161); those who had used drugs within the last week (n = 190); those reporting a problem with more than one drug (n = 131); those in insecure housing (n = 85) and those reporting mental ill-health (n = 294) were not less likely, or only slightly less likely, to report progress. For each of these different groups, at least 65% of respondents still reported that the support from services was now better than two years ago.

Free text responses about changes to the support offer

When asked why things were improving, 101 respondents ticked the 'other' response option and provided a free text comment. There were a number of recurring themes across these free text comments.

There is now more support from community and recovery groups

First, the free text comments suggested that respondents feel that there now is more support from community and recovery organisations. This was the 'other' improvement referenced most frequently.

> Recovery communities [are] developed a lot more, and there for people in need. (Respondent 134)
>
> Recovery cafés [are now] set up in the local community, which is a massive help. (Respondent 162)

> [There now are] more options of support away from just addiction services. (Respondent 49)

ADRS services are improving

Second, a number of free text comments suggest that respondents noticed improvement in ADRS services. Some suggest more progress than others.

> The change in addiction services is massive, they have been a great support and to be honest more than I ever thought they would be. (Respondent 12)
>
> I find it a little bit easier (but not much) to access addiction workers. (Respondent 222)

A number of respondents gave specific examples of what had improved in ADRS services. Several explicitly referenced the MAT standards. Others pointed to staff attitudes.

> I cannot stress enough that same day / next day prescribing makes a massive difference... (Respondent 203)
>
> [It relates] to [the] introduction of the MAT standards; staff treat me much better. (Respondent 322)
>
> Services listening to peer voices. (Respondent 208)
>
> Less stigma. (Respondent 359)

Access to mental health support has improved for some

Third, a number of respondents commented in their free text response that access to mental health support had improved for them.

> Mental health support is now in place. (Respondent 330)
>
> [I] see a psychiatrist now. (Respondent 30)
>
> Mental health is getting better but there are still gaps with it… (Respondent 105)

Respondents feel better informed

Fourth, free text comments suggest that respondents feel better informed, about the support that is available to them, or about their rights.

> I feel I know where to go now when I need extra support, whereas in the past I wasn't sure. (Respondent 95)
>
> I feel more informed about services than in the past. (Respondent 58)
>
> I am more aware of my rights now. (Respondent 56)

Respondents themselves are in a better place

Finally, a number of respondents felt that something within themselves had changed – rather than seeing an improvement in the support they were receiving as such.

> My own motivation to come. (Respondent 276)
>
> I don't try to hide anything and tell them how it is. (Respondent 320)
>
> Myself being more engaged. (Respondent 88)

Negative changes

When asked why things were getting worse, 29 respondents ticked the 'other' response option and provided a free text comment. Most of these comments reflect a poor support experience, without necessarily an indication that the support had got worse over time. For example, respondents referred to challenges accessing mental health support or to stigma or lack of capacity in services. There were a limited number of comments explicitly reflecting a worsening of support. Respondents referred to changes made during COVID-10 still impacting on services or to increased pressure on staff.

> Things have changed since COVID, [it is now] harder to access. (Respondent 220)
>
> Services workload… staff levels have decreased (Respondent 262)

Conclusion and considerations for policy

Conclusions

This section is structured around three questions, linked to the three survey aims:

- Is there evidence that the support experience has improved and what does this mean for the evaluation – is the National Mission making a difference?
- What is the support experience currently like and where should quality improvement efforts be focused?
- What does this study tell us about the feasibility of establishing an ongoing survey to collect feedback from individuals with experience of using drugs?

Has the support experience improved – is the National Mission making a difference?

What we can and cannot conclude from the survey findings

When exploring what the survey findings may imply for the wider National Mission evaluation, it is important to reiterate that the survey was not based on a representative sample. The findings cannot be generalised to the target population (i.e. all individuals in Scotland who have experience of using drugs and who, in the last 12 months, have had support needs). For example, the target population also included those who had not received support from their local ADRS. We need to be mindful, when interpreting the survey findings, that only one in four respondents had not accessed ADRS support.

We have included a detailed description of the characteristics of respondents in this report. We have also included subgroup analysis to help explore to what extent survey findings apply to a lesser or greater extent to different groups of respondents. All this can be used to help contextualise the survey findings.

Some of the survey findings are relatively positive. For this reason, we want to be specifically mindful of the risk that more positive views could be systematically overrepresented in the survey. This risk cannot be ruled out.

However, we actively tried to mitigate against this risk by wording the questions and response options in a way that presented both positive and negative responses as acceptable (see **Limitations**). We also hypothesise that working with SDF may have helped respondents feel more comfortable to also express more negative views: SDF has been firm in its advocacy about ongoing challenges in the support offer from services. Those dissatisfied with their service experience may have been more likely to agree to participate in the survey. To the extent that this occurred, it may have offered an additional mitigation against the risk of any systematic skewing towards more positive views.

Conversely, as with any survey of this kind, the mere act of being asked for their views may have helped respondents feel more supported. Those more positively inclined on the day of the survey may have been primed to give more positive responses. These considerations would also have been at play in a survey using representative sampling.

In summary, the survey findings can help inform the wider evaluation provided that:

- They are interpreted alongside the detailed information on who responded to the survey
- Stakeholders acknowledge that the survey design aimed to mitigate against the risk of response bias but that this cannot be ruled out
- The findings are used as one input alongside other data sources, including for example routine data relating to services.

Is there any evidence to suggest that the support experience may have improved for individuals?

The survey provides some evidence which suggests that the support experience may have improved and that this may, in part, be a result of the National Mission. We provide examples below.

First, seven in ten survey respondents report that the support they are getting from services now is better than two years ago. It is not possible to unambiguously attribute this to the National Mission. However, the response options ticked most frequently as examples of improvements (for example, faster access to support or more respect from services) chime with key National Mission priorities. A number of free text responses also directly link the improved support offer to National Mission programmes, including for example the MAT standards. A hypothesis of progress in the service experience also echoes findings from other work packages in the National Mission evaluation that treatment systems are being strengthened.

Second, unmet need for naloxone and OST among respondents is low. It is not possible, in the absence of baseline data, to be certain that these relatively low levels of unmet need represent an improvement. This is, however, not an unreasonable hypothesis, given the level of investment and focus on harm reduction and medication-assisted treatment in the context of the National Mission and its precursor, the Drug Deaths Taskforce.

Third, just more than six in ten respondents had received their choice of OST medication and almost seven in ten had received the first dose of their OST medication within a week of asking for a prescription. It is again not possible, in the absence of baseline data, to be certain that these data represent an improvement. It is again not an unreasonable hypothesis, given the focus within the MAT standards on choice and rapid access to OST.

A hypothesis of progress on naloxone and OST would also be in line with other data sources suggesting progress in these areas. This includes, for example in relation to choice of OST, **PHS monitoring data showing an increase in the estimated number of individuals prescribed injectable buprenorphine**. In the **2023 PHS**

frontline staff survey, substantial proportions of respondents also felt better able to offer MAT and harm reduction as a direct result of the National Mission.

Fourth, the free text responses provide some evidence to suggest that access to support from community and recovery groups may have improved. This was the improvement referenced most frequently in the free text comments on changes to the support offer. It is not possible to unambiguously link this to the National Mission, but it again chimes with National Mission activity: National Mission funding has been allocated to national organisations who help establish and support community and recovery groups.

Evidence to suggest ongoing challenges

The survey findings also provide evidence which suggests that challenges remain in relation to a number of National Mission programmes and that progress has been more limited for some people.

First, two in ten respondents report that the support they are getting from services now is worse than two years ago. For example, some respondents report that they now have to wait longer for support or are seen less frequently. This echoes findings from the **2023 PHS frontline staff survey**: staff responding to that survey reported 'trade-offs' and having to deprioritise some client needs.

Second, one in three respondents had not received their choice of OST medication and only four in ten (41%) had received their first dose of OST medication on the day they had asked for a prescription, or the next day. The **same-day prescribing MAT standard** states that all individuals accessing services have the option to begin medication on the day they ask for help.

Third, unmet need for residential rehab is relatively high among respondents, despite the levels of focus and investment in this treatment option. Moreover, more than four in ten (45%) respondents who had accessed residential rehab reported that it had been difficult for them to do so. This 45% percentage is based on responses from a relatively small number of individuals (n = 55), which needs to be considered.

These latter findings suggest that a degree of caution may be needed when interpreting the more positive findings reported elsewhere about the MAT standards or Residential Rehabilitation programmes.

For example, the 2024 PHS lived experience survey reports a lower percentage in relation to compliance with the same-day prescribing MAT standard than the **2025 MIST benchmarking report** (41% compared to 86% in the MIST report). These two percentages are not necessarily incompatible, as they are based on different definitions[ii]. The PHS lived experience survey used the exact wording of the MAT standard in its questionnaire and as such is a more direct reflection of compliance with the standard from the perspective of individuals. However, the relatively small number of respondents for this question in the PHS lived experience survey (n = 164) needs to be considered. The possibility of bias in the data also needs to be considered, for both studies.

Similarly, the 2024 PHS lived experience survey reports a lower percentage relating to ease of access to residential rehab than the earlier **2023 PHS survey of individuals who were in residential rehab** at the time of the survey (47% compared to 76% in the earlier 2023 survey). The number of respondents was relatively low in both instances (n = 55 and 108), which needs to be considered. The possibility of bias in the responses also needs to be considered, for both surveys.

[ii] In the PHS MIST benchmarking report, 86% of ADPs are marked as compliant. ADPs are marked as compliant if 75% of individuals have received their MAT assessment on the same day as their initial presentation, or on the next day. Rural or remote ADPs need to achieve this within five days to be marked as compliant. The MIST assessment also uses process and experiential evidence.

What is the support experience currently like – and what are the implications for quality improvement efforts?

What is the support experience currently like?

The findings relating to respondents' experience of trying to access support from their local ADRS, or other services, present a snapshot. We have no earlier baseline data on, for example, the number of respondents who reported that they felt listened to by their local ADRS.

However, a degree of contextualisation is possible. Overall, six in ten (60%) respondents in the PHS lived experience survey rated the care they had received from their local ADRS in the last 12 months as excellent or good. The most recent data from the Scottish Health and Care Experience (HACE) showed that 69% rated their overall experience of their GP practices as excellent or good and 63% rated their help, care or support services as excellent or good (**2023-2024 HACE data**). The overall ratings of local ADRS support are slightly lower but broadly in line with these percentages.

Set against the backdrop of earlier PHS evaluation findings about workload pressures on frontline staff, it is worth celebrating that six in ten respondents describe the quality of their relationship with their ADRS key worker as excellent or good. Almost four in ten (38%) rated the quality of this relationship as excellent. This is higher than the proportion of respondents who give a rating of excellent to ADRS care overall (28%).

This may suggest that further efforts to improve ADRS care also, or mostly, need to focus on systems and processes, as opposed to the practice of individual members of staff. It is, for example, worth noting that those seen at least every two weeks by their ADRs were more likely to rate ADRS care as excellent or good. They were also more likely to report that they were getting all or most of the support they needed.

Pharmacists and mental health workers also emerged as staff groups likely to be experienced as supportive.

However, the survey findings clearly suggest ongoing challenges in the current support experience. For example:

- Substantial proportions of survey respondents report unmet need or indicate that overall they are not getting all or most of the support that they need.
- The ADRS support experience is poorer in certain areas, such as for example making individuals feel in control of their treatment and treatment goals.
- Half of respondents report that they had experienced stigma or discrimination from their local ADRS service at some point in the last 12 months – be it mostly rarely or occasionally.
- Respondents were only a little more likely to describe their GP practice as supportive than as unsupportive.
- The free text responses relating to unmet need – including examples of waiting a long time for mental health support or rough sleeping upon leaving prison – act as stark reminders of ongoing challenges.

Subgroup analysis and a more in-depth review of survey findings can help pinpoint more clearly where the scope for improvement lies. Caution is needed when attempting to draw conclusions from the subgroup analyses (**Limitations**). It is also worth reiterating that support needs or client characteristics cannot be seen in isolation – even if, in what follows, the survey findings around scope for improvement are presented as such. A holistic, whole-system, person-centred response is needed.

Scope for improvement for specific target groups

The survey findings suggest scope for improvement for a number of groups.

1. Women

The first group are women. Female respondents were less likely to rate ADRS support as excellent or good. They were less likely to have been offered harm reduction support (including naloxone) or employment support. They were more likely to report unmet peer support needs.

2. Individuals living in rural areas

The second group are individuals living in rural areas. Respondents from rural areas reported higher levels of unmet need for a number of treatment and care options, including naloxone and other harm reduction support, OST, peer support and employment support.

3. Individuals who are homeless

The third group are individuals who are homeless. Respondents in insecure housing were less likely to rate ADRS support as excellent or good or report that they were getting all or most of the support they needed. They were more likely to report unmet needs for housing support or residential rehab.

4. Individuals in recovery

The survey findings also suggest that there is scope for improvement for individuals in recovery. Respondents in recovery were less likely to have received support from their local ADRS in the last 12 months. This was despite these respondents having ongoing support needs in relation to their past drug use (as per the eligibility criteria for this survey). Respondents in recovery were also more likely to report unmet need for peer support and mental health support in a group and, and for naloxone and other harm reduction support.

5. Families and loved ones

Finally, the survey findings also suggest scope to improve engagement with families and loved ones. Respondents were least likely to agree with the statement that they had been given the opportunity to involve the people that mattered to them. Only a relatively small number of respondents ticked the response option that it was now easier to involve their family or friends if they wished to do so.

Scope for improvement around non-opioid substance use

The survey findings suggest that there continues to be substantial scope to improve the support offer around non-opioid drug use.

Unmet need for treatments for drugs other than opioids stood at 28% – this was the third highest unmet need reported by survey respondents, out of a total of 14 different unmet need response options. Stimulants, not opioids, were the category most commonly reported as the main problem drug.

Respondents who reported stimulants as their main problem drug or who reported a problem with benzodiazepines were less likely to give a positive rating to ADRS care. The latter group was also less likely to report that they had received all or most of the support they needed. Respondents who reported a problem with opioids were more likely to think that the support offer they were receiving from services was better now than two years ago.

This echoes the consensus from across other work packages of the evaluation that the National Mission may have focused insufficiently on drugs other than opioids. It is also in line with **PHS quarterly Rapid Action Drug Alerts and Response (RADAR) reports** which, for example, have highlighted the leading role cocaine currently plays in drug harms.

We did not find evidence to suggest that the support experience was worse for respondents who also had a problem with alcohol, alongside their problem with drugs. This may be because of confounding factors. There is evidence from other work packages of the evaluation that there is scope for improvement around alcohol.

Scope for improvement relating to specific treatment modalities

The survey findings in relation to levels of total demand and unmet need for different treatment options can help inform post-2026 investment decisions, alongside other evidence. There are a number of key messages.

1. Total demand and unmet need for mental health support are high

Mental health support emerged as the biggest support need in this study. The vast majority of respondents reported mental ill-health. One-on-one mental health support was the treatment option with the highest levels of total demand and highest level of unmet need among respondents, both by some margin. This was the case across all subgroups, further underlining the extent of need. Mental health support was not defined in the survey as such, but the wording in the questionnaire ('counselling or mental health support, one-on-one') nudged respondents to interpret this question as referring to talking therapies.

Unmet mental health needs also emerged as the most prominent theme in the free text responses. Many of those free text comments related to unmet need for support from specialist mental health services. Free text comments also reflected a need for human connection and for more trauma-informed ways of working. At times, requests for mental health support reflected the need for better trauma-informed support or for human connection, instead of, or alongside, a need for professional mental health input.

2. Total demand for peer support is high

The second highest level of total demand was for peer support. Peer support was defined in the survey as, for example, recovery communities, recovery groups or cafés or networks for people who use drugs. Unmet need for peer support was relatively low among respondents overall, with however higher levels among specific groups (see **It is also worth reiterating that support** needs or client characteristics cannot be seen in isolation – even if, in what follows, the survey findings around scope for improvement are presented as such. A holistic, whole-system, person-centred response is needed.

Scope for improvement for specific target groups). Unmet need for peer support may be substantially higher than suggested in the survey: it is likely that those already in contact with peer support groups are overrepresented.

Requests for additional investment in peer support also featured prominently in the free text responses. This included requests to have more individuals with experience of using drugs in statutory services and to invest more in community and recovery groups, and more generally in support recovery and relapse prevention.

It may be worth referencing here that support from third sector, community and recovery groups was endorsed as positive across the free text responses. This stood in contrast to support from statutory services, where free text comments presented a mix of more positive and more negative experiences.

3. Total demand for harm reduction (including naloxone) and OST is high

With regard to harm reduction and, when only including respondents who report a problem with opioids, also with regard to OST, the survey suggests high levels of total demand but low levels of unmet need. The high levels of total demand caution against relaxing the level of investment in these areas but the low levels of unmet need are encouraging. Higher levels of unmet need among specific subgroups (see **It is also worth reiterating that support** needs or client characteristics cannot be seen in isolation – even if, in what follows, the survey findings around scope for improvement are presented as such. A holistic, whole-system, person-centred response is needed.

Scope for improvement for specific target groups) may suggest scope for more targeted investment and improvement efforts. The finding that female respondents are less likely to report receiving naloxone, despite being as likely to use it, is particularly worth noting in this context.

In the case of OST, the finding that unmet need for OST was concentrated among respondents who had accessed OST is worth noting. It possibly cautions against too strong a focus on increasing OST take-up and argues for ongoing efforts to improve the OST offer for those already in receipt of OST. This finding possibly echoes the ambivalence about the OST treatment target (which is aimed at increasing OST take-up) reported in the **ADP coordinator survey**: the same proportion of respondents thought that the OST target was helping as thought that it was hindering.

4. Unmet need for residential rehab, housing support and drug checking is high

Finally, it is worth noting the high levels of unmet need for residential rehab, housing support and drug checking. The second highest level of unmet need related to residential rehab.

Feasibility of an ongoing national survey

A short briefing paper presenting the methodology and findings of the feasibility component of the study will be published separately. This is because some of the feasibility questions cannot be answered before stakeholders have had an opportunity to engage with the published findings.

It is, however, possible to already make a number of preliminary observations:

- The survey suggests that it is feasible to engage enough individuals with experience of using drugs to allow for meaningful analysis. There are important limitations which need to be considered (**Limitations**). Several analyses would be more robust with a higher number of respondents. A larger survey may also allow for additional subgroup analysis. This could include analysis by ADP area. Further discussion as to whether a future survey would need to aim for representativeness may be beneficial.

- The survey suggests that it is possible to also engage individuals with more complex needs, such as individuals in insecure housing, and to engage those in rural areas. The survey was less successful in engaging with young people, individuals with an ethnicity other than white and individuals in prison, and with individuals from the three island ADPs. More targeted efforts are likely needed to incorporate the perspective of these groups. Stakeholders have also suggested scope to target other specific groups, such as those in recovery.

- The vast majority of responses were secured as a result of the proactive outreach by SDF peer researchers. Only working with self-completion is not a realistic prospect for a research project of this type.

- Some wording in the survey was kept generic (e.g. 'support from services'). Clearer definitions in future iterations of the survey may help to better pinpoint possible implications for policy or service development.

- A full assessment of the added value of the survey will only be possible after stakeholders have had an opportunity to engage with the published survey findings. However, the survey findings have already been presented by PHS in a series of workshops. Feedback from stakeholders confirm that the findings are directly relevant to ongoing policy and service development efforts.

The purpose and scope of this survey were linked, to a large extent, to the aims and objectives of the PHS evaluation of the National Mission. The Scottish Government will wish to revisit the question of purpose and scope for future iterations of the survey. Other data sources, including for example DAISy, would need to be considered when determining the scope. Possible future objectives could include:

- Tracking of individuals' experience of ADRS support, or of the support offered by a wider range of statutory or third sector organisations
- Supporting monitoring of progress in relation to MAT standards, access to naloxone or other treatment options, replacing or complementing existing reporting requirements
- Supporting tracking of unmet need and total demand for different types of treatment, care or support
- Supporting tracking of (proxy) outcome indicators, such as the proportion of respondents reporting good quality of life or being in recovery.

Considerations for policy

Discussions are currently ongoing on what comes after the National Mission ends in March 2026. This report, including its findings about levels of demand and unmet need for different treatment options, can be used as one input in those discussions.

The evidence suggesting progress possibly argues in favour of a degree of continuity, giving time to local and national organisations to continue existing quality improvement efforts. This might also help avoid putting unhelpful additional pressure on staff, which was previously identified as an unintended negative consequence of the National Mission.

However, evidence of ongoing challenges suggests that some areas may benefit from additional or more targeted focus and investment. Earlier work packages in the evaluation have already highlighted scope for improvement. These issues are already being considered as part of the post-March 2026 discussions. This report provides further evidence that scope for improvement remains, including for example in terms of:

- Mental health support, including improving access to specialist mental health services and embedding trauma-informed working across services
- Investment in peer support and third sector, community and recovery groups
- The support offer in relation to non-opioid drug use, including stimulants
- The needs of groups facing additional disadvantage, including for example individuals who are homeless.

In addition, the Scottish Government may wish to consider establishing a longer-term research project to allow aspects of this survey to be continued.

Next steps

This survey is part of the wider PHS evaluation of the National Mission. In the final year of the National Mission, we are undertaking research to explore the impact of the National Mission on families and loved ones and to help inform discussion about the question whether the National Mission investment has presented value for money. A synthesis evaluation report is anticipated to be published in 2026.

Appendix 1. Relevant data collection exercises

The biannual **HACE** survey tracks the experience of individuals accessing health or social care services, but the HACE questionnaire does not include any questions relating to problematic drug use or drug treatment services. It is not possible to undertake subgroup analysis of HACE responses for those individuals who reach out for support for problematic drug use. The HACE team explored options for incorporating a relevant question, but this was assessed as not feasible because of sample size constraints and pressure on the length of the questionnaire.

The annual **Scottish Health Survey (SHeS)** already includes a drugs module every two years and would allow (further) subgroup analysis of the health of respondents with experience of using drugs. However, SHeS aims to explore individuals' health and not their experience of health or support services. The SHeS team explored options for incorporating a question on the support experience but this was assessed as not appropriate, given the scope and purpose of the questionnaire.

The **NESI** questionnaire is a large-scale biannual survey of individuals who inject drugs. Similar to the SHeS survey, it is not aimed at exploring individuals' experience of support services but instead focuses on the health harms experienced by individuals who inject drugs.

The experiential work stream of the PHS **MIST** team supports local ADPs to collect qualitative feedback from service users. This work is set up as quality improvement work rather than research. The qualitative feedback collected through this work stream does not provide robust baseline data against which progress can be tracked.

Healthcare Improvement Scotland have undertaken qualitative work with individuals with problem drug use[iii] but, as with the MIST experiential work stream,

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[iii] See for example the reports published by Healthcare Improvement Scotland in the context of its work with Alcohol and Drug Partnerships on **homelessness**.

the qualitative feedback does not provide robust baseline data against which progress could be tracked for the purpose of the evaluation.

A **2021 study by Scottish Drugs Forum**[iv] explored how individuals with problem drug use experience OST services and support. This study includes some quantitative data which can offer a (partial) baseline against which progress could be tracked. However, the study focused only on a single treatment option (OST) and was limited to six health boards. A total of 95 individuals participated.

A **2023 survey of about 300 individuals with recent experience of using drugs**, commissioned by PHS in the context of the evaluation of the Scottish Government's Residential Rehabilitation programme and undertaken by Figure 8, a research consultancy, provides some quantitative data against which progress could be tracked. A simple rating-scale question asking individuals to rate their experience of the services they had accessed over the last twelve months was included in the questionnaire. However, this is limited to a single question and a basic rating-scale. It does not provide sufficient detail to act as a comprehensive baseline of individuals' views on the availability, accessibility and quality of the support offer.

Routine data collection relating to the provision of drug treatment (through the **DAISy database**) includes a number of indicators which can act as proxy measures for the availability, accessibility and quality of care. This includes, for example, the number of individuals receiving support, the number of unplanned discharges and waiting times. These indicators will help inform responses to the evaluation questions, but they are only proxy indicators. They do not negate the need to collect feedback directly from individuals with experience of trying to access drug treatment services.

[iv] Scottish Drugs Forum, 2021. Medication Assisted Treatment. Service evaluation of people's experience of accessing MAT in six Health Board areas across Scotland.

Appendix 2. SDF method and approach

Three SDF staff from the Research and Peer Engagement team were initially involved in this work. In October 2024, another staff member joined the team, and they were also involved. These staff provided feedback on initial versions of the survey questionnaire, trained peer research volunteers for this work, engaged with services to promote recruitments, and supported and facilitated data collection.

Thirteen peer research volunteers engaged in the initial sessions SDF held relating to this work. People had the option to attend online or in person. Sessions involved peers providing feedback on early versions of the survey tool, receiving training on facilitating the survey and practicing using tablet devices to do this.

Quality assurance was considered at all stages. Staff provided opportunities for peer researchers to role play and practice the survey during training. Peer researchers were able to shadow SDF staff members completing the survey with participants at the beginning of the data collection period. SDF staff attended all except one instance of data collection activity. Therefore, they could provide support to peers as required. Only minimal help was needed (e.g. some help with using the tablets or navigating the appropriate questions on paper copies of the questionnaire). The research team had debriefs following every data collection activity and allowed for more formal reflective practice at regular group meetings.

SDF staff initiated contact with services and groups across Scotland or used existing contacts and networks in local areas. They got in touch to promote the work and sought opportunities to attend the services with peer researchers to facilitate recruitment and completion of surveys.

A wide range of services / groups engaged with the work and were attended by SDF staff and peer researchers to facilitate surveys, including:

- Four NHS clinics and one NHS outreach service
- Three criminal justice projects
- Eleven SDF engagement groups

- Ten recovery cafés / communities

- Twelve third sector services

- One prison establishment

- One rehabilitation establishment.

Appendix 3. Treatment and care options

The ten treatment and care options were worded as follows in the questionnaire:

- MAT / opioid-substitution therapy (e.g. methadone, buprenorphine)
- A naloxone kit
- Other harm reduction support (e.g. needle exchange or wound care)
- Detoxification (community / inpatient)
- Residential rehabilitation
- Counselling or mental health support, one-on-one
- Counselling or mental health support, in a group
- Peer support (e.g. recovery communities, recovery groups / café, networks for people who use drugs)
- Employment support
- Housing support.

Respondents could also tick the following two options:

- I have not received any treatment or support
- Something else (please specify)